Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Title:	Board Assurance Framework Report
Report to:	Trust Board
Date:	27 March 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 includes 12 identified risks to achieving the Trust's revised organisational objectives which were agreed by the Trust Board on 4 April 2016.

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

- Risk 3.1.8 – 'If the Trust fails to deliver the Trust's Budget for 2016 / 2017' decreased its risk score from 6 (Medium) to 2 (Low) as the Trust was forecasting a better than planned otturn.
- Risk 3.1.10 – 'Failure to procure and implement a new IT systems supplier from June 2017' increased its risk score from 16 (High) to 20 (Catastrophic) as it is almost certain that the Trust will not have a new IT provider in place by the deadline. However, mitigating actions are being taken to ensure continued IT support from the existing provider.
- In addition to the above, two risks (1.1.2 and 2.1.5) remain rated as 'High', whilst all other risks remain rated as 'Medium'.
- Four risks (1.2.4, 3.1.8, 3.1.9 and 3.1.11) continue to achieve or exceed their respective tolerable risk score. Five risks require a risk score movement of 3 or more to achieve their respective tolerable risk score.

Recommendations:

The Trust Board is asked to:

1. Note the updates provided for each risk.
2. Note the changes to the risk score for the following risks:

   3.1.8 - If the Trust fails to deliver the Trust's Budget for 2016 / 2017 – risk score has decreased from 6 to 2.

   3.1.10 - Failure to procure and implement a new IT systems supplier from June 2017 – the risk score increased from 16 to 20.

3. Identify any further actions which may be required to address or further mitigate risks, and any additional risks for inclusion in the BAF.

Sponsor:	Mary Sexton, Executive Director for Nursing, Quality and Governance
Comments / Views of the Report Sponsor:	The BAF sets out details of the 12 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 Board Assurance Framework 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 Board Assurance Framework 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 2016 / 2017. 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. 2016 / 2017 Board Assurance Framework

2.1 Barnet, Enfield and Haringey Mental Health Trust agreed the following **Aims** and *Objectives* at the Trust Board meeting held on 4 April 2016:

1. Provide excellent services for patients (coloured yellow)

1.1 Provide excellent quality of care and improve the experience of all our patients, including responding to the recommendations of the CQC inspection in 2015.

1.2 Develop our enablement programme ("Live, Love, Do") further with patients, carers, partners and our staff.

1.3 Work more closely with other local organisations to help deliver place-based care.

2. Develop our staff (coloured purple)

2.1 Develop each member of staff and help them to deliver excellent care.

2.2 Increase the engagement of our staff – evidenced in improved Staff Survey results.

3. Meet our financial and other targets (coloured blue)

3.1 Provide the best possible outcomes for patients, meeting national and local NHS requirements within the resources available - evidenced by meeting agreed targets.

3.2 Develop our estate in line with our clinical strategy.

2.2 Summary of Risks

2.2.1 The Board Assurance Framework for 2016 / 2017, attached as Appendix 1, contains 12 risks, which are summarised below:

Risk		Initial Risk	31 May 2016	18 July 2016	26 September 2016	28 November 2016	30 January 2017	Current Risk	Tolerable Risk
1.1.1	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.	12	9	9	12	12	12	12	9
1.1.2	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.	12	12	12	16	16	16	16	9
1.1.3	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.	20	12	12	12	12	12	12	9
1.2.4	If the Trust fails to deliver operational and financial efficiencies through Enablement this will affect the sustainability of the Trust.	12	9	12	12	12	12	12	12
2.1.5	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.	16	16	16	16	16	16	16	12
2.1.6	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.	20	12	12	12	12	12	12	9
2.2.7	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.	20	12	12	12	12	12	12	9
3.1.8	If the Trust fails to deliver the Trust's Budget for 2016 / 2017 the Trust will not be able to meet its Control Total or be financially sustainable going forward.	15	15	15	15	6	6	2	12
3.1.9	If the Trust does not manage its Liquidity position then the Trust will be unable to pay its creditors and staff.	16	16	16	16	12	12	12	12
3.1.10	Failure to procure and implement a new IT systems supplier from June 2017 will impact on staff workload and effectiveness, and will have a detrimental impact on the activity recording, quality and safety of services.	12	12	12	12	16	16	20	12
3.1.11	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.	20	16	16	12	12	12	12	12
3.2.12	Failure to modernise the 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.	16	12	12	12	12	12	12	9

2.2.2 The table above highlights the progress of each risk over the course of the year. The Trust Board is asked to note the current position of each risk.

2.3 Heat Map

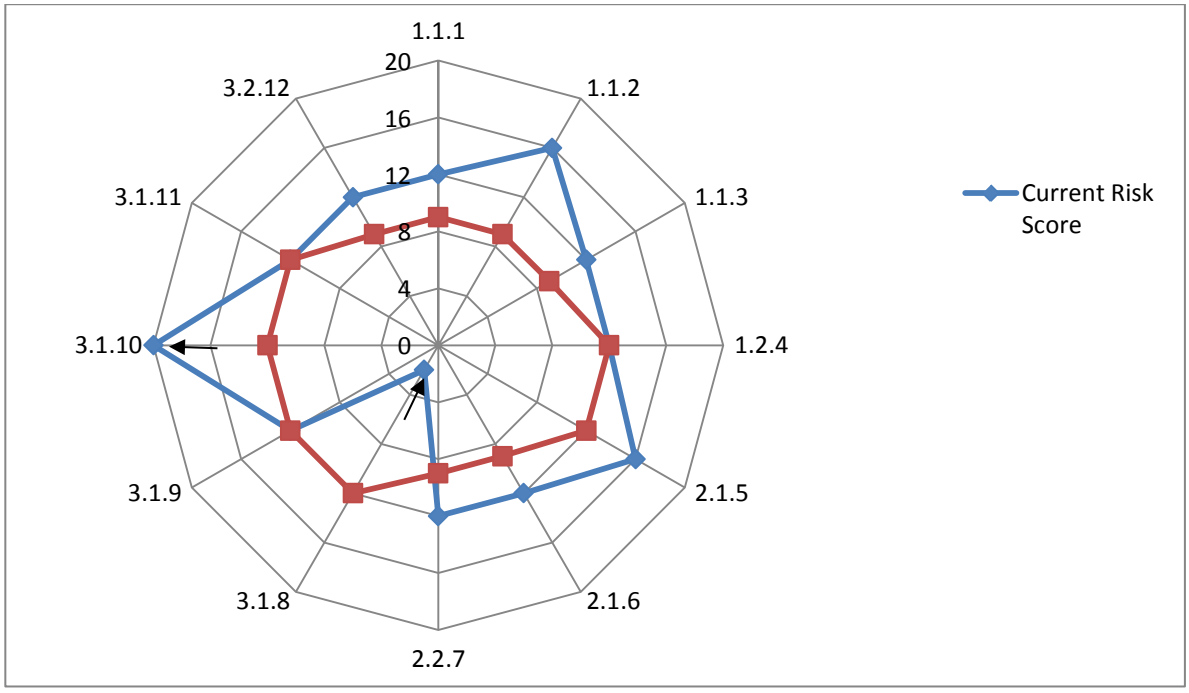
2.3.1 Set out below is a heat map showing the relative position of each of the risks contained in the BAF, and the direction of travel for any risk where there has been a change in the risk score.

RISK RATING MATRIX					
Impact / Likelihood	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)				3.1.10	
Likely (4)			3.1.9	1.1.2, 2.1.5	
Possible (3)			3.1.11	1.1.1, 1.1.3, 1.2.4, 2.1.6, 2.2.7, 3.2.12,	
Unlikely (2)		3.1.8			
Rare (1)					
Impact Score x Likelihood Score = Risk Rating:					

2.4 Achievement of Tolerable Risk Score

2.4.1 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.

2.4.2 Four risks have achieved or exceeded their respective tolerable score. The difference between current risk score and tolerable risk score is demonstrated below:



2.5 '**High Rated' Risks**

2.5.1 The three highest rated risks as highlighted by the 2016 / 2017 BAF are:

1.1.2 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.

2.1.5 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.

3.1.10 Failure to procure and implement a new IT systems supplier from June 2017 will impact on staff workload and effectiveness, and will have a detrimental impact on the activity recording, quality and safety of services.

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

2.6 **Mitigating Actions**

2.6.1 Set out below 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**
1.1.1	Independent Freedom to Speak Up Guardian to be appointed.	Two Independent Freedom to Speak Up Guardians have been appointed.	MS / MV	~~February 2017~~ Completed
1.1.2	Internal audit of the Quality Improvement Plan.		MS	Quarter 4
	'Must Do' compliance actions and 'Should Do' actions contained in the Quality Improvement Plan (QIP) within the Trust's ability to deliver.		EMT	Dates set out in the QIP
1.1.3	Actions arising from the Internal Audit of 'Incidents and Learning Lessons'	Reported to the Audit Committee	JB / MSW	Completed
	New procedures and reporting requirements required for deaths from 1.4.17.	New action.	JB / MSW	1.4.17
	Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.	New action	JB	
1.2.4	Commissioners have met and will not invest in transformation during 2016/17 (31/10/15).	Being raised through the STP process.	AG	On hold
	Proposals being developed to work with Third Sector partners to secure the benefits of Enablement.	New action	AG	
2.1.5	Review of recruitment plans and Staff Survey plans by the Workforce Compliance Sub-Committee	Recruitment plans updated at 6 weekly Recruitment meetings and Workforce Sub-Committee.	MV	Ongoing

Risk	Action	Update since last reviewed by Trust Board	Board Lead	Deadline / Status
2.1.6	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	Ongoing
	Development of communication channels across the Trust as well as introduction of staff networks e.g. Better Together, LGBT	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	MV	Ongoing
2.2.7	Independent Freedom to Speak Up Guardian to be appointed.	Two Independent Freedom to Speak Up Guardians have been appointed.	MS / MV	~~February 2017~~ Completed
	Communications campaign to highlight sources of support.	Promoting Dignity at Work Advisors and employee assistance programme	MV	Ongoing
	Training for managers and staff in handling inappropriate behaviours.	Programme of workshops is in development – will be a managers' session and one for staff	MV	Ongoing
3.1.8	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.		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.	New action	SG	Ongoing
3.1.9	Financial management systems and processes rigorously applied.		SG	Ongoing
	Discussions with NHS Improvement regarding the need to make cash available to sustain current service provision.	The Trust has applied for cash support and received £3.5m in February and has requested £6.5m for March.	SG	~~Ongoing~~ Completed
3.1.10	Undertake discussions with HPE to provide extended exit support	Update set out in the BAF entry.	JD	~~31.03.17~~ Ongoing
	Undertake due diligence checks	Update set out in the BAF entry.	JD	~~24.02.17~~ 31.05.17
	Actions set out in the Internal Audit report			~~Ongoing~~ Completed
	Finalise contract with new Managed Print provider	New action	JD	31.05.17
	Finalise and agree Transition plan with all suppliers (inc. HP)	New action	JD	31.05.17

Risk	Action	Update since last reviewed by Trust Board	Board Lead	Deadline / Status
3.1.11	Activity recording will be queried at team level and teams where under-recording is an issue will be supported to improve	Activity recording continues to be monitored against team-level delivery plans.	AG (Alex Manya)	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	New action	Alex Manya	For review in July
3.2.12	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	September ~~July~~ 2017
	Design work on new MH facilities	Will commence in April, once new design and build contractor appointed.	JM	September ~~July~~ 2017
	Application for final Planning approval from Haringey Council	Planning application will be developed with new design and build contractor, once appointed.	AW	September ~~July~~ 2017
	Commencement of building works at St Ann's Hospital	Dependant on NHSI approval of OBC (Oct – Nov 2017) and FBC (Mar – April 2018).	AW	May ~~March~~ 2018

Key to Deadline / Status:	Red = Overdue / deadline extended	Amber = Ongoing / deadline not yet due	Green = completed as expected	White = new action added

Implications

3. Budgetary / Financial Implications

3.1 The Board Assurance Framework 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.

Appendix 1

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Board Assurance Framework

2016 / 2017

Presented to Trust Board on 27 March 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 **Aims** and *Objectives* at the Trust Board meeting held on 4 April 2016:

1. Provide excellent services for patients (coloured yellow)

1.1 Provide excellent quality of care and improve the experience of all our patients, including responding to the recommendations of the CQC inspection in 2015.

1.2 Develop our enablement programme ("Live, Love, Do") further with patients, carers, partners and our staff.

1.3 Work more closely with other local organisations to help deliver place-based care.

2. Develop our staff (coloured purple)

2.1 Develop each member of staff and help them to deliver excellent care.

2.2 Increase the engagement of our staff – evidenced in improved Staff Survey results.

3. Meet our financial and other targets (coloured blue)

3.1 Provide the best possible outcomes for patients, meeting national and local NHS requirements within the resources available - evidenced by meeting agreed targets.

3.2 Develop our estate in line with our clinical strategy.

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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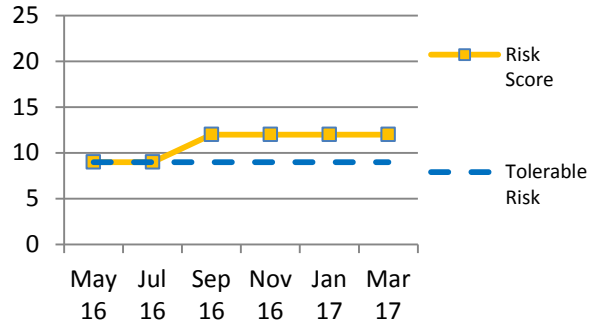
Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Provide excellent quality of care and improve the experience of all our patients, including responding to the recommendations of the CQC inspection in 2015.	**Board Lead:**	Mary Sexton	**Date of review:**	March 2017
				Lead Committee	Quality and Safety	**Date of next review:**	May 2017
Risk ID:	**1.1.1**	**Risk:**	**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 4 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⟺



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

Indicator	Dec	Jan	Feb	16/17 Target
Number of serious incidents	5	5	7	
Number of Never Events	0	0	1	0
Formal Complaints received	10	23	18	
Overall Patient Satisfaction	86%	87%	88%	80%
Overall Carer Satisfaction	93%	89%	91%	80%
Nursing Vacancy Rate	17.1%	15.8%	15.1%	10%
Staff Turnover (total)	13.4%	13.5	13.0%	15%
Proportion of staff compliant with individual mandatory training requirements	79%	78%	81%	85%

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 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 not yet delivered additional funding to address Child and Adolescent Mental Health Services (CAMHS) and returners from leave.

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 being rolled out across the Trust (I).
2. Quality Account, which details the quality priorities for the Trust:	• Quality Account priorities considered by Quality and Safety Committee on 3.05.16 and Trust Board on 13.06.16 (I). • Six monthly update reports to the Quality and Safety Committee (I) and Joint Performance and Quality (E) meetings.

<table>
<tr><td></td><td>• Quality metrics reported to every meeting of the Quality and Safety Committee and Trust Board via the Integrated 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 5.9.16 (E).</td></tr>
<tr><td>3. Statutory Committees in respect of Safeguarding, Health and Safety and Infection Control.</td><td>• Safeguarding Annual Report 2015 / 2016 considered at Quality and Safety Committee on 4.07.16 and by the Trust Board on 18.07.16 (I).
• Infection Control Annual Report considered at Quality and Safety Committee on 4.07.16 and by the Trust Board on 18.07.16 (I).
• Annual Health and Safety Report considered at Quality and Safety Committee on 3.05.16 and the Trust Board on 31.05.16 (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 (I).</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 (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).</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).</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 appointed – commencing 3/4/17.</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 and Complaints Annual Report considered at Quality and Safety Committee (last considered on 4.7.16) (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. ~~Independent Freedom to Speak Up Guardian to be appointed.~~</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>Independent Freedom to Speak Up Guardian to be appointed.</td><td>Two Independent Freedom to Speak Up Guardians have been appointed.</td><td>MS / MV</td><td>~~February 2017~~ 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></td><td>The CQC have indicated that the Trust will be re-inspected in the ~~first~~ second quarter of 2017 / 2018.

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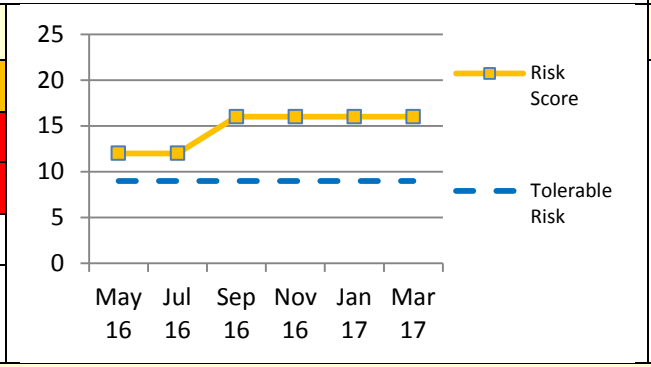
Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Provide excellent quality of care and improve the experience of all our patients, including responding to the recommendations of the CQC inspection in 2015.	**Board Lead:**	Mary Sexton	**Date of review:**	March 2017
				Lead Committee	Quality and Safety	**Date of next review:**	May 2017
Risk ID:	**1.1.2**	**Risk:**	**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:	4 x 4 = **16**
Current Risk Score:	4 x 4 = **16**
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	41	28
Should Do	208	12	106	90

Correct as at 5 January 2017.

Rationale for current score:

The Risk Score remains the same as there remains a high likelihood of a high impact on the risk as there are a number of 'Must Do' actions that require investment in order to be delivered.

The Trust has 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 Trusts 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. As at 5 January there remained 3 'Must Do' actions and 12 'Should Do' actions for which little or no evidence had yet been submitted.

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's Eating Disorder service (Phoenix Ward) was inspected in early March 2016. The CQC has notified the Trust of a number of compliance actions that the Trust needs to address. A plan is being ~~has been~~ agreed ~~and work is in progress to deliver compliance.~~

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 ~~17.01.17~~6.03.17 (I). • Internal audit of the Quality Improvement Plan ~~planned to be undertaken in Quarter 4 (I).~~ completed, and presented to the Quality and Safety Committee on 4.3.17. • 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 discussions have taken place with Commissioners regarding funding to deliver plan (E).

<table>
<tr><td>2. Internal Peer Assessment Programme which mirrors CQC inspections.</td><td>• Twice yearly Thematic Review of Service Peer Reviews considered by the Quality and Safety Committee (last considered on 7.11.16).</td></tr>
<tr><td>3. Quality Review Week, to provide evidence of progress made and inform practice.</td><td>• ~~Robust plans being developed to undertake a Quality Review Week to review progress across the Trust (I)~~
• Quality assurance monitoring in place and variations from standards are being actively addressed at team and Borough level.
• Quality Review Week held in the week commencing 23 January 2017.
• Results of the Quality Review Week presented to the Quality and safety Committee on 6.3.17 (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>• 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>Internal audit of the Quality Improvement Plan.</td><td></td><td>MS</td><td>Quarter 4</td></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></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 will be 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 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.

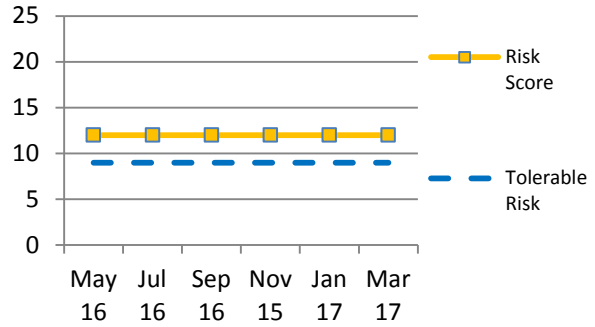
Regular meetings are held with the CQC to provide an update on progress made. The CQC have indicated that the Trust will be re-inspected in the second ~~first~~ quarter of 2017 / 2018.

Linked to Risk 1959 on the Corporate Risk Register.</td></tr>
</table>

Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Provide excellent quality of care and improve the experience of all our patients, including responding to the recommendations of the CQC inspection in 2015.	**Board Lead:**	Jonathan Bindman	**Date of review:**	March 2017
				Lead Committee	Quality and Safety	**Date of next review:**	May 2017
Risk ID:	**1.1.3**	**Risk:**	**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 4 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⇔



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

Indicator	Dec	Jan	Feb	16/17 Target
Number of serious incidents	5	5	7	
Never events	0	0	1	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 ~~remains difficult to evidence and quantify~~ 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.

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.

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 and, Deep Dive Meetings which includes moderate and serious incidents (I). • Regular reports quarterly to the Joint Performance and Quality 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 (E). • A Summary of SI data presented to the Quality and Safety Committee (reported on six-monthly basis, last reported on 7.11.16). • Internal Audit Report conducted by RSM into 'Incidents and Learning Lessons' concluded that there was partial assurance, but all recommendations now completed and final action, revision of Management of Incident Policy, ratified at the Quality and Safety Committee on 4.6.16 (I). • Reporting of all deaths, and review by the Patient Safety Team of all reports though additional requirements are expected for inpatient deaths from 1.4.17(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 7.11.16) (I). • Regular report to the Joint Performance and Quality (JP&Q) meeting with commissioners (E).
4. Serious Incident Review Groups	• Borough Serious Incident Review Groups established and last met on 9.3.17 (I). • Trust wide Serious Incident Review Group established (Trust Board 25.01.16) (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?)

1. ~~Internal Audit finding of partial assurance in respect of 'Incidents and Learning Lessons'~~.
2. Review of existing procedures and reporting requirements to comply with the new requirements concerning the reporting of deaths come into effect on 1.4.17
3. Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.

Mitigating actions: (What more should we do?)

Action	Update since last reviewed by Trust Board	Lead	Deadline
~~Actions arising from the Internal Audit of 'Incidents and Learning Lessons'~~	Reported to the Audit Committee	~~JB / MSW~~	Completed
New procedures and reporting requirements required for deaths from 1.4.17.	New action.	JB / MSW	1.4.17
Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.	New action	JB	

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

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 2016 / 2017, which reflects issues identified 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. A total of ~~7,7~~ 7,595 incidents reported for Qs 1, 2 & 3 – a 49% increase in reporting.
6. The total number of 'serious' incidents reported and declared for 2016 / 2017 is ~~48~~ 63 to year date.

Additional Comments:

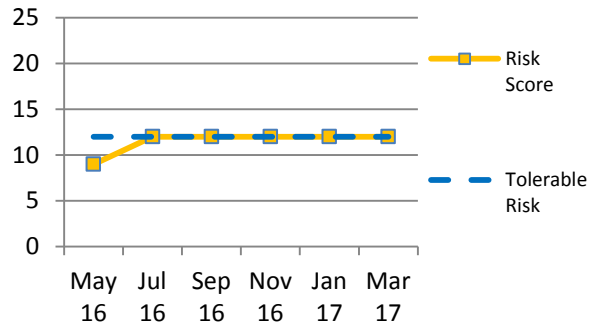
A meeting has been held with NELSCU and the Trust is working with our commissioners to resolve identified issues including receiving late information requests from NELSCU which delay closure of SI's. It has been recognised by commissioners there has been improvements in both quality of reports and completion of reports on time.

A 'never event', administration of insulin through a non-insulin syringe, took place in February. The patient was not affected. A Board level Panel Inquiry is in progress.

Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.2 - Develop our enablement programme ("Live, Love, Do") further with patients, carers, partners and our staff.	**Board Lead:**	Andy Graham	**Date of review:** March 2017
				Lead Committee		**Date of next review:** May 2017
Risk ID:	**1.2.4**	**Risk:**	**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 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)

Indicator	Dec	Jan	Feb	16/17 Target
Percentage of people in receipt of Community Mental Health services who are in settled accommodation	77%	77%	77%	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	26%	23%	23%	20%
Assessment Services DNA Rate	16.2%	16.6%	16.2%	15%

Rationale for current score:

The Risk Score remains the same as there remains a medium likelihood of a high impact on the risk as the Trust has not received additional funds to support transformation and will therefore need to deliver within current resources. Other priorities may distract from the delay of the enablement programme. Partner agencies may disengage to pursue other priorities, e.g. financial uncertainty.

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

1. Enablement Board is now integrated with the Improvement and Delivery Board.
2. Engagement of all key internal and external stakeholders.
3. Planned programmes of major changes (a. Adult Mental Health Pathway and b. Rehabilitation)
4. Develop and support Enablement Project Managers.
5. Enablement Project Plan.
6. Borough based partnerships established.
7. Rehabilitation Service Working Group established.

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

- Regular reports providing an update to the Trust Board (I).
- Regular reports to the Improvement and Delivery Board (I).
- Enablement project communications campaign (I).
- ~~Enablement Project Plan (I).~~
- ~~Borough based partnerships established (I).~~
- ~~Rehabilitation Service Working Group established (I).~~
- Adult Mental Health Pathway Review ~~information event held on 1.07.16~~complete in Barnet and underway in Enfield and Haringey (I).
- Regular fortnightly meetings of the Improvement and Delivery Board (I).
- Project plans in place for adult pathway review in each borough and rehabilitation project. ~~These are the main deliverables for enablement in 2016/17~~

<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.
2. Involvement of Third Sector partners.</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>
<tr><td>Proposals being developed to work with Third Sector partners to secure the benefits of Enablement.</td><td>New action</td><td>AG</td><td></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.

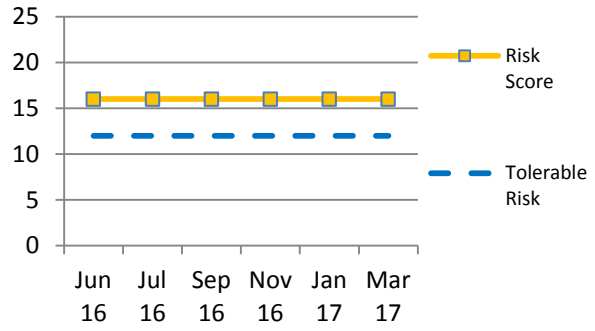
The Trust has recruited eight Community Engagement workers in place with lived experience.</td><td>The Trust is developing an ambitious change programme to ensure that all clinical services are delivering Enablement based care to patients. This is supported by commissioners, local authorities and other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

Linked to Risk 1547 on the Corporate Risk Register.</td></tr>
</table>

Board Assurance Framework – Develop our Staff

Objective:			2.1 - Develop each member of staff and help them to deliver excellent care.	**Board Lead:**	Mark Vaughan	**Date of review:**	March 2017
				Lead Committee	Workforce Compliance Sub-Committee	**Date of next review:**	May 2017
Risk ID:	**2.1.5**	**Risk:**	**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	Dec	Jan	Feb	16/17 Target
Agency as a % of Employee expenditure	6.8%	7.7%	6.4%	10%
Bank as a % of Employee expenditure	8.3%	8.4%	10.3%	7%
Total vacancy rate (% established posts without staff members in place)	12.4%	10.3%	9.9%	10%
Nursing Vacancy Rate	17.1%	15.8%	15.1%	10%
Staff Turnover (Total)	13.4%	13.5%	13%	15%

Rationale for current score:

The Risk Score remains the same as there remains a high likelihood and a high impact on the risk. This is in recognition that despite a concerted efforts the level of vacancies is not declining at a pace that is required to provide assurance to the Trust.

The Trust continues to undertake a range of recruitment activities which has led to a declining trend in vacancy levels, albeit at a slower pace than desired with total vacancy levels to ~~12.4%~~9.9% in ~~December~~ February and Nursing vacancy levels to ~~17.1%~~15.1%. The Trust continues to undertake a range of recruitment activities which has led to a declining trend in vacancy levels, albeit at a slower pace than desired with total vacancy levels to 9.9% in February and Nursing vacancy levels to 15.1%. Work is nearly complete in relation to validation of vacancies, particularly the medical establishment. This has resulted in medical vacancies against the corrected establishment declining to 7.8%. Reporting on the same will be made available through the Integrated Performance Meeting and the Improvement and Delivery Board.

~~There has been an increase in establishment in November and December, particularly in nursing and medical roles that has contributed to the increase in vacancy levels. Work is underway with borough leads to validate the vacancies in the establishment. This is being carried out in recognition of the fact that not all roles are being actively recruited to. Preliminary feedback suggests that this will have an impact on overall vacancies, and particularly on medical vacancies. Reporting on the same will be made available through the Integrated Performance Meeting and the Improvement and Delivery Board.~~

There are a range of initiatives underway to support the recruitment campaigns. Apart from the continued campaign to address nursing vacancies, the international recruitment campaign has begun. Interviews on skype with candidates in the EU have started to take place. A panel of three clinical managers will visit the Philippines at the end of March for further recruitment. In addition, work is underway with clinical leads to develop competency frameworks and rotation plans that will support the retention of nursing staff. ~~the Executive Management Team have approved a proposal to initiate an international recruitment campaign. This process is now underway and international advertising with the support from the recruitment agencies will commence in the next few weeks. In addition, work is underway with clinical leads to develop competency frameworks and rotation plans that will support the retention of nursing staff. There has been steady recruitment to medical vacancies which has also had an impact on locum bookings across the Trust.~~

A large number of process improvements have been made to improve the time to hire, including expediting of Occupational Health clearance, using text messages to maintain contact with candidates and simplifying the recruitment process for internal transfers. Further changes are being implemented, including an amendment of the ID checking process to address related delays. These changes have had the effect of reducing the time taken by the recruitment team to complete pre-employment checks though this will remain under regular review. An SLA has also been agreed with recruiting managers to ensure that there are clear agreed timelines shortlisting and interviewing.

Spend on agency has declined in ~~December~~February and reflects a trend for declining bookings since the second quarter of 2016. The trend isindicative of medical and non-medical bookings. ~~The volume of bookings has declined steadily since the second quarter of 2016. Medical agency bookings have declined with five substantive appointments having recently been made; and this is expected to decline further.~~

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. Learning and Development and Training Plan. 2. Workforce Development and Study Leave Policy, including arrangements for Performance Development Framework. 3. Recruitment Policy. 4. A Service Level Agreement for the recruitment service is now in place to improve accountability and transparency within the services and the recruitment function. 5. Streamlining recruitment process for bank staff with new staff being placed on the bank unless they opt out. 6. Rolling recruitment advertising for a range of posts including bank nurses and HCAs, RGNs and RMNs with standardised job descriptions and assessment processes is now in place and has resulted in a regular recruitment cycle. 7. TRAC recruitment software package (including eDBS function) implemented to support the recruitment process. Further improvements have been delivered by integrating the OH functionality within it. This has resulted in improved tracking and monitoring of OH clearances. 8. Monitoring of time to hire data to ensure that appropriate pressure is maintained on the pace of recruitment activity 9. 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. 10. Vacancy Control Panel, led by Executive Directors, meeting weekly since July 2016 to review all recruitment and non-urgent temporary staffing requests. 11. 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. 12. There has been an increased level of engagement with universities to recruit newly qualified nurses and mental health workers with over 40 newly qualified nurses starting this year. 13. 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. 14. Electronic exit interview monitoring is now in place and feedback from the interviews is being shared with boroughs to inform changes and remedial action. 15. A career development framework (including rotational programmes) has been launched to help retain nurses within the organisation. A competency framework is being finalised for community nursing roles. 16. 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. This is expected to have a further impact on agency bookings and vacancies over the next few months. 17. 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. 18. 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.	• 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).

<table>
<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. 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 Workforce Sub-Committee</td><td>MV</td><td>Ongoing</td></tr>
</table>
</td></tr>
<tr><th>**Current performance:** (With these actions taken, how serious is the problem?)</th><th>**Additional Comments:**</th></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.

New Staff Survey Action Plan for 2016 being presented to the Trust Board on 27.03.17 and will then be communicated across the Trust supported with local Divisional plans.

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

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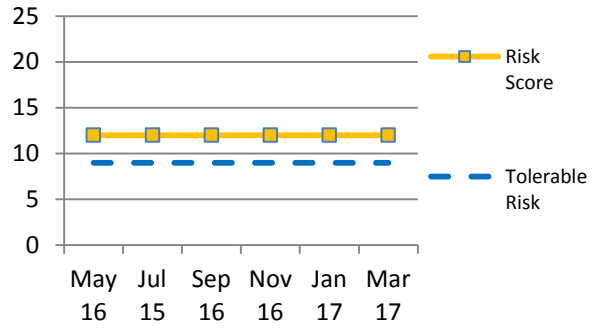
Board Assurance Framework – Develop our Staff

Objective:			2.1 - Develop each member of staff and help them to deliver excellent care.	**Board Lead:**	Mark Vaughan	**Date of review:**	March 2017
				Lead Committee	Workforce Compliance Sub Committee	**Date of next review:**	May 2017
Risk ID:	**2.1.6**	**Risk:**	**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	Dec	Jan	Feb	16/17 Target
% of staff who have completed mandatory training	79%	78%	81%	90%
% of staff who have received an appraisal	78.3%	78.3%	78.3%	90%

Rationale for current score:

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

The appraisal cycle for 2016 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). The appraisal return rate has improved to 85% though there may still be an element of under-reporting. The appraisal paperwork has been refreshed and will be published by the end of March. ~~plateaued at 78% although it is anticipated that this is being under-reported. Work is underway to refine the appraisal paperwork and design a~~ Appraisal training workshops have been scheduled for April and May~~for rollout in March - May~~, to coincide with the annual appraisal window for 2017 / 2018.

~~The Trust has identified issues with mandatory training including compliance and the provision of training courses. The Trust continues to identify initiatives to improve mandatory training compliance including streamlining refresher programmes, issuing quizzes and targeting staff that are not compliant. The Trust has introduced monthly DNA reports for managers which is intended to raise awareness of non-attendance.~~ Mandatory training compliance continues to improve, albeit slowly. 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.

~~The Trust is half way through a programme of "Living our Values" sessions will be held in April, following which we will develop a behavioural framework to help embed the values in everything that we do.. The sessions have been very well received and, from them, the Trust is developing a positive behavioural framework to support bringing the values to life and be embedded in everything the Trust does.~~ The remaining "Living our Values" sessions will be held in April, following which we will develop a behavioural framework to help embed the values in everything that we do. Feedback from the sessions has been overwhelmingly positive.

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. Workforce Development and Study Leave Policy, including arrangements for Performance Development Framework and appraisals.	• Workforce KPIs, including appraisals, revalidation, compliance with mandatory training, staff turnover and vacancies (I).

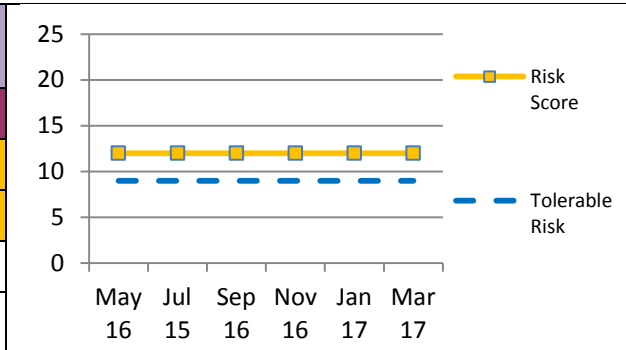
<table>
<tr><td>2. Training Panel processes for the agreement of training.
3. Recording appraisals on Electronic Staff Record
4. Booking and recording course attendance on Electronic Staff Record
5. Regular updates on training opportunities through Trust communication channels</td><td>• Regular reports 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).~~for 2015 showed an improvement in 29 of 32 key findings.~~
• Workforce Information Reporting Engine Database (WIRED) IT system which shows levels of compliance from Trust-wide to individual level (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><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. 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</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</td><td>MV</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 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 Trust is awaiting the results of the 2016 Staff Survey in order to assess the effectiveness of staff engagement~~The results were published on 07 March.</td><td>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 ~~additional~~ staff ~~that were~~being required to undertake additional elements of mandatory training, which has had a negative effect on mandatory training compliance.</td></tr>
</table>

Board Assurance Framework – Develop our Staff

Objective:			2.2 - Increase the engagement of our staff – evidenced in improved Staff Survey results.	**Board Lead:**	Mark Vaughan	**Date of review:**	March 2017
				Lead Committee:	Workforce Compliance Sub Committee	**Date of next review:**	May 2017
Risk ID:	**2.2.7**	**Risk:**	**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 2015 Staff Survey and the Trust maintaining its position as one of the top 100 NHS organisations to work for. There remains a medium likelihood of a high impact on the risk.

An action plan was developed following the results of the 2015 Staff Survey, which continues to be implemented.

The Trust approved revised Values at the Quality and Safety Committee meeting held on 4.07.16 which was reported to the Trust Board on 18.07.16. The Trust launched a Trust-wide engagement process, consisting of a series of workshops for staff to help embed the values and identify values-based behaviours. Over 20 sessions have been held so far and have been very very well received.

The annual national Staff Survey was launched in September and closed in December. The Trust is awaiting the results of the 2016 Staff Survey, likely to be published in February.

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

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

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

- Regular reports to the Workforce Committee, which reports to the Quality and Safety Committee (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 considered at Trust Board on 26.09.16 (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 (I).

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

1. Staff confidence in using sources of support for reporting concerns

Mitigating actions: (What more should we do?)

Action	Update since last reviewed by Trust Board	Lead	Deadline
~~Independent Freedom to Speak Up Guardian to be appointed.~~	Two Independent Freedom to Speak Up Guardians have been appointed.	~~MS / MV~~	~~February 2017~~ Completed
Communications campaign to highlight sources of support	Promoting Dignity at Work Advisors and employee assistance programme	MV	Ongoing
Training for managers and staff in handling inappropriate behaviours	Programme of workshops is in development – will be a managers' session and one for staff	MV	Ongoing

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

~~The annual Staff Survey showed an improvement from 3.54 out of 5 to 3.70 out of 5 in 'Staff confidence and security in reporting unsafe clinical practice'. The national average for Mental Health is 3.70.~~

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.

~~In April 2016, the Trust undertook a survey to gain staff views on the Trust's Values. The results are informing a programme of activity involving staff to identify values-based behaviours that we wish all staff to adopt, thus bringing the Trust values to life. The sessions started in the week beginning 21 November 2016 with good feedback being received.~~The final "living our values" sessions will take place in April 2017. Take-up has been good (over 1,200 staff so far) and feedback very positive. Staff feedback from sessions is being developed into a new behavioural framework, intended to illustrate positive, constructive behaviours and will be integrated to our workforce process from induction to performance management.

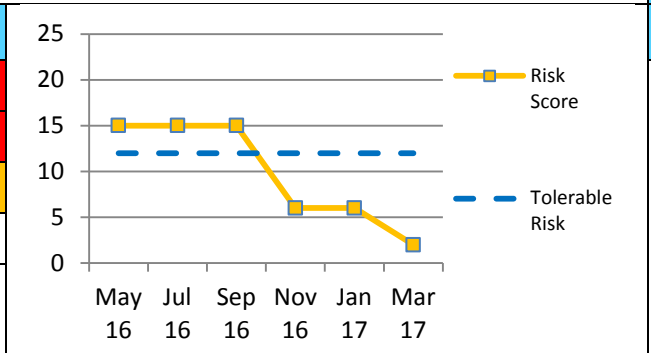
Additional Comments:

The Workforce Compliance Sub-Committee monitors the Staff Survey results and Values survey, and the agreed action plans.

Board Assurance Framework – Meet our financial and other targets

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:**	Simon Goodwin	**Date of review:**	March 2017
				Lead Committee:	Finance and Investment	**Date of next review:**	May 2017
Risk ID:	**3.1.8**	**Risk:**	**If the Trust fails to deliver the Trust's Budget for 2016 / 2017 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 2 = **6**
Current Risk Score:	1 x 2 = **2**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⇧



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

Indicator	Dec £000's	Jan £000's	Feb £000's	16/17 YTD £000's	16/17 Forecast £000's
Budget – surplus / (deficit)	(986)	(1,186)	(1,151)	(11,365)	(12,589)
Actual performance – surplus / (deficit)	(839)	(1,082)	(1,017)	(11,166)	(11,900)
Variance to budget – Favourable / (adverse)	147	103	134	199	698

Rationale for current score:

The Risk Score has decreased ~~remains the same~~ (a low~~medium~~ likelihood but with a low impact). The Trust is still managing the risk around beds, agency spend is reducing and several opportunities have ~~been identified that are likely to~~ manifested in the final quarter of 2016 / 2017, The forecast outturn is deficit of £11.9m, reduced from £12.6m. On this basis the confidence in delivering the financial plan has increased and the risk score decreased.

The Trust has a Budgeted Deficit for 2016 / 2017 of £12.6m. This is £3.5m higher than the Control Total imposed by NHS Improvement. The Trust is managing a number of financial risks (articulated in the monthly Financial Performance Report), which in aggregate threatens achievement of the budgeted deficit. The Trust is taking part in a Financial Improvement Programme, led by NHS Improvement. As a result the Trust has established a Programme Management Office, led by a Turnaround Director, and has engaged a Director of Improvement. The Trust is now performing better than planned and has adjusted the forecast outturn accordingly. ~~For two months the Trust has delivered a performance better than budget and is within £38k of the year to date plan.~~

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.£4m of savings. 6. Monthly Integrated Performance Meetings to review Service Line performance, risks and opportunities. 7. Monthly review of financial performance of each Service Line. 8. Implementation of Improvement and Delivery Board	• 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 savigns 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></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></td><td>SG</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>There is a substantial gap between income and expenditure for 2016 / 2017 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.

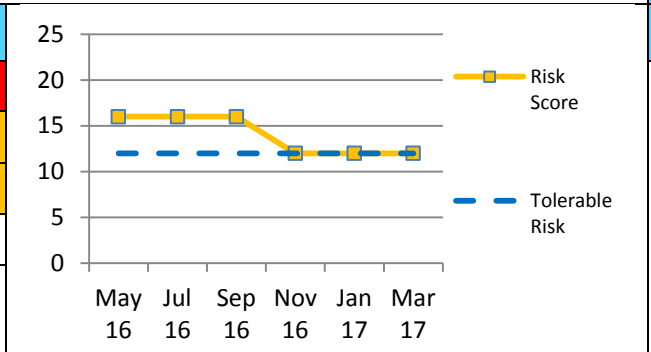
The main emphasis, as set out in the Carnall Farrar report, commissioned by the CCGs, is around system wide working and better alignment of income with expectations around service provision. This has now moved on to include a pricing review as part of the STP and 17/19 contracting round.

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 – Meet our financial and other targets

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:**	Simon Goodwin	**Date of review:**	March 2017
				Lead Committee:	Finance and Investment	**Date of next review:**	May 2017
Risk ID:	**3.1.9**	**Risk:**	**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 3 = **12**
Current Risk Score:	4 x 3 = **12**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



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

Indicator	**Dec**	**Jan**	**Feb**
Liquidity Ratio (Days)	-30.3	-32.1	-32.6
Net Cash Flow - surplus / (deficit) (£000's)	(2,373)	(2,399)	(703)
Current Cash Balance - surplus / (deficit) (£000's)	4,028	4,001	3,298

Rationale for current score:

The Risk Score remains the same as ~~there remains a high likelihood of a medium impact on the risk as the Trust is forecasting that there will be a need for cash support in February.~~ the Trust is now reliant on cash support from the Department of Health.

The Trust has applied for cash support and recived £3.5m in February and requested £6.5m for March. ~~Regular updates are received form NHS improvement as to the process to access cash. NHS Improvement have issued to the Trust a letter of support which confirms that cash will be made available at a sufficient level to avoid the Trust running out of cash during 2016 / 2017.~~

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. Ongoing discussions with NHS Improvement.
8. The Trust has applied for cash support and received £3.5m in February and has requested £6.5m for March.

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.

Gaps in controls and assurances: (What additional controls and assurances should we seek?)	**Mitigating actions:** (What more should we do?)
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.	

Action	**Update since last reviewed by Trust Board**	**Lead**	**Deadline**
Financial management systems and processes rigorously applied.	Ongoing	SG	Ongoing
~~Discussions with NHS Improvement regarding the need to make cash available to sustain current service provision.~~	The Trust has applied for cash support and received £3.5m in February and has requested £6.5m for March.	~~SG~~	~~Ongoing~~ Completed

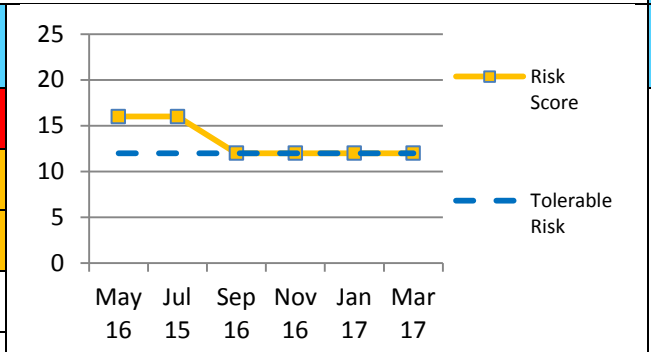
Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
The Trust is applying the recently approved national controls re agency nursing. These are not expected to have a significant impact on the cost base, but will help to an extent. The main emphasis, as 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.	Linked to the Financial Performance Report.

Board Assurance Framework – Meet our financial and other targets

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:**	Andy Graham (Alex Manya)	**Date of review:**	March 2017
				Lead Committee:	Performance Improvement	**Date of next review:**	May 2017
Risk ID:	**3.1.11**	**Risk:**	**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 3			Qtr 4	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**
Activity Recording - Percentage variance from contracted activity plan (CCG Contracted Activity)	3.8%	14.2%	6.9%	5.5%	9.0%
Patient FFT - Mental Health Response Rate	7.3%	8%	8%	8%	8.50%

Rationale for current score:

The Risk Score remains the same. The likelihood of information being incomplete has reduced through the new controls (5) 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. ~~there remains variance against from the contracted activity plan and therefore there is a medium likelihood of the risk materialising which may have a potentially high impact~~.

While the in-month variance from plan has seen peaks and troughs, the year-to- December variance from planned activity is +4%. Given that the plan was partly based on previous years' activity data, which is known to have been underreported; a 4% increase is roughly what should be expected as we approach the end of the year.

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	• 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).

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.

- 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?)

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.

Mitigating actions: (What more should we do?)

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 will be supported to improve.	Activity recording ~~is~~ continues to be ~~now being~~ monitored against team-level delivery plans.	Alex Manya	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	New action	Alex Manya	For review in July

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

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.

Additional Comments:

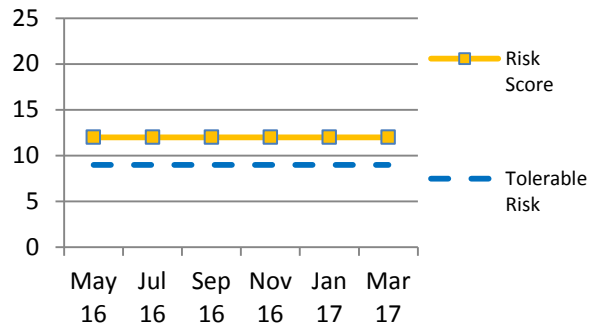
The 'live' nature of the reporting database is less of a problem for board-level decision making than it is for retrospective analyses and CCG assurance. By the start of 17/18 we expect to have implemented a read-only database, providing access to reports that will remain static.

Board Assurance Framework – Meet our financial and other targets

Objective:			3.2 - Develop our estate in line with our clinical strategy.	**Board Lead:**	Simon Goodwin / Maria Kane (John Mills / Andrew Wright)	**Date of review:**	March 2017
				Lead Committee:	Estates Sub Committee	**Date of next review:**	May 2017
Risk ID:	**3.2.12**	**Risk:**	**Failure to modernise the 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)

Indicator	**Dec**	**Jan**	**Feb**	**16/17 Target**
Estates Maintenance - proportion of jobs that are unplanned	51%	54%	51%	55%

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.	• Estates Sub Committee established at the Finance and Investment Committee on 21.11.16 (I). • 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 26.09.16 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).

<table>
<tr><td></td><td>

- 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).

</td></tr>
<tr><td>

2. Adherence to the Estates and Facilities work programme.
3. Delivery of agreed NCL Estates Strategy.

</td><td>

- Estates and Facilities KPIs (I).

</td></tr>
<tr><td>

4. Implementation of the re-development of the St Ann's Hospital site to provide new mental health inpatient facilities.

</td><td>

- Following SOC approval, the next stage involves appointing a new design and build contractor for the new mental health facilities, following Wilmott Dixon's decision to withdraw. An appointment is due by early April 2017. Following this, work will progress 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 ~~July~~ 2017.

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5. Ligature Mitigation Work Plan.

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- 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 May 2015 (I).
- Update report presented to the Quality and Safety Committee on 17.01.17 (I).

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

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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	September ~~July~~ 2017
Design work on new MH facilities	Will commence in April, once new design and build contractor appointed.	JM	September ~~July~~ 2017
Application for final Planning approval from Haringey Council	Planning application will be developed with new design and build contractor, once appointed.	AW	September ~~July~~ 2017
Commencement of building works at St Ann's Hospital	Dependant on NHSI approval of OBC (Oct – Nov 2017) and FBC (Mar – April 2018).	AW	May ~~March~~ 2018

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<tr><td>**Current performance:** (With these actions taken, how serious is the problem?)</td><td>**Additional Comments:**</td></tr>
<tr><td>A five year programme (2015 – 2020) for mitigating ligature risks is in the process of being implemented. Approximately £500k was programmed in year one, with a further expenditure of £2M over the following four years.</td><td>~~The PLACE inspection for 2015 was positive with no significant concerns raised. The majority of minor issues have been addressed with remaining issues being monitored through monthly Environmental Operations Action Group meetings.~~

Ligature programme linked to Risk 1592 on the Corporate Risk Register.</td></tr>
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