


<p>North East Strategic Health Authority</p> <p>North West Strategic Health Authority</p> <p>Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	
<p>Date: 19 January 2012</p>	<p>Report Author: Jo Dally – Associate Director (Corporate Business) NHS Yorkshire & the Humber</p>
<p>Title of paper: Risk Monitoring Report</p>	
<p>Actions Requested: The Board is asked to approve the content and format of the Board Assurance Framework, incorporating the corporate risk register on an interim basis pending final confirmation of priorities and objectives for NHS North of England</p>	
<p>Governance Requirements</p>	
<p>SHA Objectives supported by this paper: Effective operation during transition – ensure organisational and system resilience and business continuity, including in relation to all statutory obligations</p>	
<p>Risk Management: Organisational and system instability during transition adversely affects corporate performance – as evidenced by sustained good governance, effective internal control and the transition assurance process</p>	
<p>Board Assurances: The Board Assurance Framework summarises the controls and assurances in place to mitigate the principal potential risks that threaten delivery of the corporate objectives.</p>	
<p>Risk Assessment:</p> <ul style="list-style-type: none"> • Risks have been assessed in accordance with the methodology set out on page 2 of the document. Lead directors have assured the scoring. • Where gaps in controls or assurances have been identified these are summarised in the document, along with mitigating actions. 	
<p>Communication (including public and patient involvement): The draft BAF has been approved by SMT. Once approved by the Board it will be communicated to all staff via internal communications mechanisms</p>	
<p>Resource Implications – including productivity and value for money: No additional resource needs identified for risk management and assurance</p>	
<p>Legal Implications: It has not been necessary to obtain legal advice in relation to this paper</p>	

Equality and Diversity:

No specific E&D issues identified

NHS Constitution:

Effective internal control is consistent with principles of governance and accountability

North East Strategic Health Authority
North West Strategic Health Authority
Yorkshire and the Humber Strategic Health Authority

19 January 2012

Risk Monitoring Report

Introduction

A Board Assurance Framework (BAF) and Risk Register need to be in place to support Board governance and to enable the Chief Executive, as Accountable Officer, to sign the Statements of Internal Control for the three statutory organisations comprising the North of England cluster at the year-end.

Background

Each of the three constituent SHAs had effective and established assurance and risk processes in place prior to clustering. The BAFs of each SHA were signed off immediately prior to clustering and were referenced within the suite of corporate documentation supporting the handover process.

The recent visit by the Department of Health to assure the handover process for the North of England incorporated a review of the arrangements for the management of risk.

The corporate risks set out by each SHA would normally be expected to require ongoing treatment while ever the associated objectives remained in place. Ordinarily it would not be necessary or appropriate to draw up a new BAF in-year. However, the North of England Board has requested that a set of priorities is confirmed for the period from the establishment of the cluster to 31 March 2013. Accordingly a new BAF has been drafted for NHS North of England, which will define the high-level potential risks to the corporate priorities, once agreed, and summarise the controls and assurances that are in place or are planned.

Current Position

Ideally it would have been preferable for the Board to have had an opportunity to discuss and agree objectives in advance of the drafting of the BAF. As this has not been possible, a set of high-level objectives has been drafted as a starting point that encompass the 5 main areas of SHA activity (strategic leadership; partnership & engagement; system development; workforce development; and performance and productivity), with the addition of 'effective operation during transition', to reflect the current context.

An analysis of the objectives of the constituent SHAs has been undertaken and mapped to the draft priorities identified here to ensure that all areas are broadly captured.

Further work is currently being undertaken by SMT to refine the objectives and priorities and to identify the key indicators of success and the milestones towards these. Reporting on progress against these milestones and key success criteria will form the basis of the reporting of assurances to the Board.

There will be an opportunity for a further discussion around the priorities and objectives at the Board development event scheduled for 23 January and so the attached BAF will serve as an interim draft BAF until the Board has had an opportunity to review the objectives and priorities for NHS North of England in more depth and to confirm them. Where necessary, refinements and amendments will be made to the BAF following the event on 23 January and it is proposed that the revised BAF should then be reviewed by the Audit Committee on 14 March, along with a draft proposed Risk Strategy for NHS North of England, before being brought back to the Board in May 2012.

Current Risk Management Arrangements

The three SHAs have established risk management processes in place that have been reviewed and approved by auditors. These processes will continue until a revised strategy and process is agreed for the cluster.

Recommendation

The Board is asked to approve the form and content of the attached draft BAF, if appropriate on an interim basis pending final confirmation of corporate objectives.

The Board is asked to delegate review of the next iteration of the BAF to the Audit Committee, along with approval of a risk strategy and process for the cluster.

The Board is asked to agree to further review the BAF at its meeting in May 2012.

Elaine Darbyshire
Director of Communications & Corporate Affairs
19 January 2012

NHS NORTH OF ENGLAND
RISK MONITORING REPORT:
ASSURANCE FRAMEWORK AND RISK REGISTER
OCTOBER 2011- MARCH 2013

(v2 04 Jan 2012)

Principles of the Approach

This document is intended to be dynamic. Each potential risk is given a score (risk level) that is derived from consideration of the probability of the risk arising and the consequences for the achievement of the objective (or impact), if it does. This score should take account of the controls and assurances that are in place to mitigate the risk.

Where gaps are identified in controls or assurances, a corresponding action plan is included. A second 'anticipated risk score' is then calculated, which reflects the level of risk posed to the achievement of the relevant objective once the appropriate action has been completed. (Where the action is split into several stages, a single score is awarded for all stages).

As actions are completed, additional controls and assurances resulting from those actions should be registered in the appropriate sections. The gaps should be removed and where possible, the risk level reduced (in terms of probability and/or impact) accordingly. Risks on the assurance framework will not be removed if the risk level is reduced, but will remain so as to provide continued assurance to the Board that controls and assurances are in place.

Where after due consideration no gaps in either controls or assurances have been identified, the table will be shaded to demonstrate that data is not incomplete, but rather that is not required within that field.

Risk scores are traffic lighted: **Low-medium (1-6) = Green** **High (8-12) = Amber** **Significant (15-25) = Red**

Key to Risk Level (for full details see SHA Risk Management Strategy and Responsibilities Statement)

Prob = Probability/likelihood

Impact/Consequence

1 = Rare

1 = Insignificant

2 = Unlikely

2 = Minor

3 = Possible

3 = Moderate

4 = Likely

4 = Major

5 = Almost Certain

5 = Catastrophic

Probability x Impact = Risk Score

1 – 3 = Low Risk

4 – 6 = Medium Risk

8 – 12 = High Risk

15 – 25 = Significant Risk

NHS North of England
Assurance Framework and Risk Register Oct 2011 – March 2013

Objective: 1. Strategic Leadership

a) Produce and implement a Business Plan for the period to March 2013

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Executive	Lack of clarity of purpose during transition phase - existing improvement targets and strategies are not hardwired into developing systems	3	3	9	Health & Social Care Bill and Directions on transition Handover process Operating Framework 2012/13	Corporate Objectives (to be agreed by the NoE Board) -aligned to the Operating Framework Draft objectives for NHS NoE agreed by SMT 01-12-11 for review by NoE Board Jan 2012 Director leads identified for all objectives/priorities Planned Board reporting of delivery against trajectories All staff briefing on NoE priorities 2012/13 (held Dec 2011)	DH Transition assurance (Dec 2011)	None identified	NoE Business Plan (in development) to include success criteria and key milestones (Chris Willis)	2	3	6

Objective: 1. Strategic Leadership

b) Align current and future SHA operation with strategic direction of successor bodies

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
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Chief Executive	Organisational strategic priorities are not sufficiently ambitious or do not reconcile with the ambitions/strategies of successors	3	3	9	NoE Board-approved objectives (Jan 2012) Mapping exercise (to be undertaken Jan 2012) Transition plans agreed with organisations receiving SHA functions	SMT agreement of priorities, success criteria and key milestones Network meetings focus on delivery of strategic priorities Scheduled Board reporting on Public Health transition	DH Transition assurance DH transition milestones tracker	None identified	SMT discussion of long list of potential priorities being reviewed and refined by Medical Director/Chief Nurse Stakeholder engagement in NoE strategic priorities	2	3	6

Objective: 1. Strategic Leadership

c) Ensure system leadership capacity and capability

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Cluster Director of Workforce & Education	Leadership and talent management is not developed across the system undermining capacity and capability and impeding progress	2	3	6	NHS Leadership Framework Leadership Academies established	SHA-based initiatives including : Top Leaders diagnostic workshops Emerging Leaders Network: Recruitment campaign for new emerging leaders; Network benefits evaluation; Selection process for the new national Vanguard programme run by NHS Institute Leading Transformation Programme (learning network for very senior leaders re approaches to change and transformation Regional, national and international programmes for senior leadership development, including members of CCGs Workshops and executive coaching available for senior and emerging leaders	To be identified					

Objective: 2. Partnership and Engagement

a) To lead and facilitate an improved system in which all partners and stakeholders, patients, public and staff are aware and engaged

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Cluster Director of Communications and Corporate Affairs – with Cluster DPH and Chief Nurse	Delivery is undermined by poorly defined and ineffective external partnership arrangements	3	3	9	Process for identifying partners/ Networking Partnerships formally defined Partnership within the portfolio of Directors: DoCA – Media and stakeholder engagement; DPH – partnership development with stakeholder in the PH agenda CN – Patient engagement Implementation of national metrics from Outcomes Framework	Partners' views feed back into priority setting and transition planning Executive reports to the Board Transparency pilot implementation and roll-out	To be identified	None identified				

Objective: 2. Partnership and Engagement

b) Implementation of Public Health transition for the North of England

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place											Action Plan to Reduce Probability or Impact of Risk		
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed			
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score			
		2	3	6						2	3	6	
Cluster DPH	Failure to deliver effective partnership structures to manage the functional transfer of Public health to local government				Public Health outcomes Framework Public Health transition programme Joint Strategic Needs assessments NW Transition Executive Group (to ensure effective transition and communications with staff & stakeholders) NW Transition Oversight Group – to bring together local government, NHS and voluntary sector. NW Transition Alliance Board (provides leadership and support for PH transition)	Health inequalities Delivery Plans (re transition) GP Commissioning Consortia development programme Assurance on fit for purpose Joint Strategic Needs Assessments Provision of tools and training to LA boards Development work with Health & Wellbeing Boards Board reporting on Public Health transition Assessment of local transition plans (part of the SHA Cluster)	Planned audit review of management of transition and migration of functions	Awaiting guidance on the position of staff who may potentially transfer from the NHS to LAs Awaiting confirmation of PH shadow budgets for LAs and the NHS	Not for local action Not for local action				

Objective: 2. Partnership and Engagement

c) Develop capacity and capability in the North of England to facilitate the establishment of a functional shared service for Communications and Engagement

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	Independent Assurance	Gaps in Controls or Assurance	Action Plan How the identified gap is to be addressed and how the risk is to be diminished	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
Cluster Director of Communications & Corporate Affairs	Public confidence and the reputation of the NHS is damaged by uncertainties arising from prospective reform or change	2	4	8	<p>Strategic approach to communications across the SHA, including branding and reputation management</p> <p>Communications involvement in all major initiatives/ reviews and developments</p> <p>Communications networks</p> <p>Communications support/advice for NHS organisations</p>	<p>NoE Comms function oversight of local strategies where significant change is proposed</p> <p>Transition planning to ensure functional resilience</p> <p>Planning in support of the establishment of a national shared service for communications and engagement</p> <p>Media monitoring and reputational surveys</p> <p>Communications input to public engagement associated with Commissioning Development</p> <p>NoE assurance of local processes around planned significant service change</p> <p>NoE monitoring of potential planned major service change</p>	<p>External overview and Scrutiny</p> <p>DH overview of major service change</p>	None identified				

Objective: 3. System Development

a) Ensure robust FT pipeline plans and alternative strategies

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Cluster Dep CE/Director of Finance	Failure to identify and execute an effective strategic solution for remaining non-FTs	4	3	12	Provider Development Board (to be established) Tripartite Formal Agreement (TFA) process for aspirant FTs NoE assurance of the development of FT applications or alternative plans	Board reporting of FT pipeline progress	Scrutiny by Monitor and the Competition and Cooperation Panel DH rating of progress through the FT pipeline	NW: Director of Provider Development post vacant (from Dec 2011)	Replacement to be identified Provider Development Group to be established to monitor FT pipeline process	3	3	9

Objective: 3. System Development

b) Facilitate all CCGs in the North of England to achieve authorisation by target date (Oct 2012/March 2013)

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Operating Officer	Failure to ensure and facilitate the development of effective GP commissioning and transition to the NHS Commissioning Board	2	4	8	Establishment of PCT Clusters Cluster accountability frameworks Performance management framework includes milestones for commissioning development CCG authorisation framework Critical path profile developed Assurance process developed	Targetted programme of support for CCGs delivered through PCT clusters Scenario planning with commissioning leadership community Commissioning Development update reports to the Board Risk assessment of CCGs against the authorisation framework	DH scrutiny of CCG risk assessments	Hold clusters to account using transition scorecard	Escalation process for poorly performing clusters	1	4	4

Objective: 3. System Development

c) Engage and involve future Commissioners in current decision-making and future planning

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Chief Operating Officer	Current and future commissioners fail to identify and implement solutions to ensure safe, sustainable and affordable services	2	4	8	Stakeholder involvement/ ownership of in planned solutions and strategies Integrated Strategic and Operational Plans (ISOPs)	NoE assurance of local processes for determining solutions NoE assurance of ISOPs Deployment of additional capacity/expertise where appropriate NoE Planning Framework targetted at CCGs	DH review of ISOPs	Authorisation process requirement for clear and credible plan	Development programme, escalation and performance management of clusters	1	4	4

Objective: 3. System Development

d) Ensure the establishment and development of fit for purpose commissioning support functions

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place				Action Plan to Reduce Probability or Impact of Risk								
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Operating Officer	Transition to GP commissioning is undermined by ineffective commissioning support functions	1	4	4	Cluster accountability frameworks	Targetted programme of support for CCGs delivered through PCT clusters Scenario planning with commissioning leadership community Commissioning support organisations in development including assistance from independent advisors and North of England workshops Commissioning Development update reports to the Board All clusters set to achieve Checkpoint 1 (local) assessment	DH transition assurance process	None identified				

Objective: 4. Workforce Development

a) Lead successful implementation of Delivering the Healthcare Workforce and ensure sound stewardship of MPET resources through transition

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Cluster Director of Workforce & Education	Transition disrupts delivery of MPET SLA and/or Workforce Plans are not fit for purpose	2	3	6	'Delivering the Healthcare Workforce' Local Education and Training Boards (to be established) Contracts with education and service providers Workforce benchmarking data and metrics Provider Skills Network Programme Board established (NW)	Interim arrangements in place to prepare for the delegation of Workforce functions Consultation on education and training commissions with education and service providers. Regular W&Ed update reports to the Board	Centre for Workforce Intelligence scrutiny of commissioning plans Audit scrutiny: Y&H – 3 internal audit reports (University contracts; deanery locality arrangements; Learning & Development agreements) – all significant or full assurance	National timetable not yet published	LETBs being developed - initially established as Committees of the NoE Board	2	3	6

Objective: 4. Workforce Development

b) Ensure successful implementation of the Medical Revalidation process

-----**Risk Action**-----

Lead Director	Potential Risk Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Risk Level Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			Key Control Mechanisms The systems and processes in place that mitigate this risk	Management Assurance/Actions What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	Independent Assurance External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Gaps in Controls or Assurance Where an additional system or process is needed, or evidence of effective management of the risk is lacking	Action Plan How the identified gap is to be addressed and how the risk is to be diminished	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
		2	3	6								
Cluster Medical Director	Corporate reputation is damaged and/or services are compromised by delays or problems associated with implementation of medical revalidation	2	3	6	<p>All designated bodies have appointed responsible officers (ROs)</p> <p>SHA assurance of revalidation process</p>	<p>E-networks and learning sets being established to support ROs</p> <p>Project support and processes to facilitate assurance</p> <p>Organisational readiness self-assessments being rolled out</p>	DH assurance of revalidation arrangements	None identified				

Objective: 5. Performance and Productivity

a) Ensure delivery today – of all national targets (including 2012/13 Operating Framework) and regional expectations (Accountability Agreements)

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
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Chief Operating Officer	There is a loss of grip on current performance	3	4	12	<p>Performance management systems and processes</p> <p>Annual and mid-year review processes</p> <p>NoE Management Executive Group</p> <p>PCT Cluster strategic plans</p>	<p>Performance reporting to the NoE Board</p> <p>Targetted interventions based on risk assessments</p> <p>SHA assurance of PCT plans</p>	<p>DH monitoring against national commitments and priorities</p> <p>Internal Audit review of performance management arrangements:</p> <p>Y&H SHA – Evaluation of Single Assurance & Accountability Process</p> <p>Y&H review of PHO & QO – evaluated performance management arrangements – significant assurance</p>	None identified	Interventions via Commissioners with organisations not delivering vital signs requirements	2	4	8

Objective: 5. Performance and Productivity

b) i. Identify unacceptable variations in quality and performance, including financial performance and ensure these are effectively addressed by PCT Clusters

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan (Include lead person and end date)	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board i.e. include dates of planned Board reports	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Nurse with Cluster Medical Director	i) Productivity gains are at the expense of quality (as measured by safety, clinical effectiveness and patient experience)	3	4	12	Performance monitoring and management processes incorporate quality SUI management and independent inquiries process Legacy/handover process Quality Assurance Committee LSA process for the regulation of midwifery	Regular Board reporting on Quality: including Safeguarding; LSA function Interventions as indicated by performance monitoring of quality metrics Monitoring of action plans to address legacy issues Regular Board reporting on handover issues Quality Assurance Committee reports to the NoE Board	CQC registration and monitoring NPSA monitoring of patient safety alerts Internal audit reviews: Y&H – planned audit of safeguarding and serious incident reviews	None identified				

Objective: 5. Performance and Productivity

b)ii Identify unacceptable variations in quality and performance, including financial performance and ensure these are effectively addressed by PCT Clusters

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan (Include lead person and end date)	Anticipated Risk Score After Action Plan Completed		
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Chief Operating Officer	ii) QIPP plans fail to deliver expected benefits	2	3	6	PCT QIPP plans & programmes Single Integrated Plan	Performance monitoring and risk assessments against plans Shared learning and practice – e.g. QIPP briefings and resource packs PCT Cluster oversight of provider quality & performance	Audit review of QIPP plans (intentions to be confirmed) DH sign-off of Single Integrated Plans	None identified				

Objective: 5. Performance and Productivity

b) iii. Identify unacceptable variations in quality and performance, including financial performance and ensure these are effectively addressed by PCT Clusters

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan (Include lead person and end date)	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board i.e. include dates of planned Board reports	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Cluster Dep CE/ Director of Finance	iii) Interventions fail to deliver required outcomes, standards and improvements, including financial balance /agreed control totals	3	3	9	Financial monitoring and risk management Contract monitoring Stakeholder agreement of plans to address organisational financial challenge	Board reporting of financial situation, including financial risk NoE sign-off of financial plans Financial risk sharing arrangements Oversight of the implementation of plans to address organisational financial challenge	Audit review of financial planning DH monitoring of financial plans and ongoing monitoring of financial position	Organisations identified as posing significant financial risk	High levels of SHA monitoring for organisations posing highest financial risks	2	3	6

Objective: 5. Performance and Productivity

b)iv. Identify unacceptable variations in quality and performance, including financial performance and ensure these are effectively addressed by PCT Clusters

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan (Include lead person and end date)	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board i.e. include dates of planned Board reports	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished			
Cluster Medical Director	iv) The benefits of planned service changes and reviews are not realised	3	3	9	SHA service change assurance processes Regional service reviews e.g. Stroke, Vascular Services Stakeholder and public consultation	Assurance on affordability requirements of proposed service changes SHA quality assurance of implementation plans Reconfiguration updates to the Board	Overview and Scrutiny process NCAT review process	None identified				

Objective: 5. Performance and Productivity

c) Ensure continued improvement in quality and safety performance

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Nurse	Safety is compromised by lack of clarity on accountability, poor staff morale and loss of knowledge due to organisational and structural change	2	4	8	Legacy/handover process Knowledge & records man't processes Governance processes around transition Quality & Safety assurance programme for providers SUI and independent inquiry processes Oversight by NoE Board Committee on Quality Assurance Roll-out of E4E NW: Advancing Quality Alliance & Reduced Mortality Collaborative	Board reporting on legacy/handover process and issues Implementation of action plans derived from handover issues Transition/organisational closure planning includes actions to ensure continuity and effective handover in relation to safety Ongoing surveillance and intervention where appropriate SHA oversight of local processes Quality dashboard Transparency Pilot implementation	CQC monitoring and registration DH Transition assurance process	None identified				

Objective: 5. Performance and Productivity

d) Lead the North of England’s response to the Francis Inquiry

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Chief Nurse	Lessons of past serious untoward events are not learned and failures are repeated	2	4	8	Recommendations of the Francis Inquiry Networking linked to shared learning NoE Board Committee on Quality Assurance - remit includes receipt of SUI and independent investigation reports Transparency Pilot and roll-out NW: Energise for excellence programme being rolled out to ensure robust response to Francis Report	Board reporting on implementation of actions arising from the Francis Report Planned QA Committee reports to the NoE Board Mobilisation campaign; action learning sets; productive series and safety express Review of PCR and Trust responses to Francis recommendations endorsed by NW Directors of Nursing	Care Quality Commission registration and monitoring Internal audit review – e.g. planned audit of safeguarding and serious incident reviews (Y&H)	None identified				

Objective: 5. Performance and Productivity

e) Manage IM&T programmes to agreed targets

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Cluster Dep CE/Director of Finance	Transition disrupts the delivery of programme targets for IM&T as strategic capability is dissipated	3	3	9	National Informatics Shared Service Programme Regional programmes for IT	Board reporting on IT programmes (scheduled for March and Nov 2012) Programme management and coordination SHA locality leads assigned to PCT Clusters to assure PCT Cluster IM&T governance Ongoing work to develop and extend collaboration across localities to mitigate capacity issues	Risk monitoring by Connecting for Health and the NHS CIO	None identified				

Objective: 5. Performance and Productivity

f) Support the development and spread of innovation

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk						
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed	
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score	
Cluster Medical Director	The benefits of innovation are not maximized and/or enabling functions fail to support transformation	2	3	6	QIPP plans Regional innovation strategies and funds	Monitoring of progress with implementation of QIPP plans Proactive promotion of innovative approaches, including QIPP briefings and resource packs Arrangements in place to satisfy SHAs' statutory duty to promote innovation Annual innovation report to the NoE Board (provisionally scheduled for July 2012)	To be identified	None identified			

Objective: 6. Effective operation during transition

a) Successfully undertake the Transition Assurance process

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Cluster Director of Communications & Corporate Affairs	Organisational and system instability during transition adversely affects corporate performance – as evidenced by sustained good governance, effective internal control and the transition assurance process	3	4	12	<p>Systems of internal control</p> <p>Work to support Transition/ organisational closure</p> <p>Business continuity plans</p> <p>Budgetary management processes</p> <p>Internal and external audit plans agreed with the Audit Committee</p> <p>Information Governance arrangements</p>	<p>Risk and assurance processes embedded within constituent SHAs</p> <p>Transition plans including RAG ratings</p> <p>NoE Board-approved Corporate Governance Framework Manual (Nov 2011)</p> <p>Business impact assessments</p> <p>Board reporting on internal transition (to be programmed)</p> <p>Regular Board reporting on budgets</p> <p>Audit Committee annual report to the NoE Board (scheduled for</p> <p>NoE Risk Strategy (to be developed)</p> <p>Board reporting on</p>	<p>Audit review of systems of internal control, governance and budgetary management – SHAs and hosted programmes</p> <p>DH milestones on transition</p> <p>Staff surveys</p> <p>2010/11 Annual Audit Letters</p> <p>Annual Information Governance toolkit assessment</p> <p>Audit review of IG self-assessment</p>	None identified	NoE Risk Strategy to be produced for review by Audit Committee (March 2012)	3	4	12

Objective: 6. Effective operation during transition

a) Successfully undertake the Transition Assurance process

-----**Risk Action**-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk						
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed	
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score	
					The systems and processes in place that mitigate this risk compliance with statutory obligations and duties – e.g. Innovation; Equality & Diversity; FoI; LSA function; financial management Audit Committee scrutiny of audit reports and monitoring of implementation of actions arising from audit recommendations DH monthly report card						

Objective: 6. Effective operation during transition

b) Ensure organisational and system resilience and business continuity, including in relation to all statutory responsibilities during transition

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level Prob Impact Score			Key Control Mechanisms	Management Assurance/Actions What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	Independent Assurance	Gaps in Controls or Assurance	Action Plan How the identified gap is to be addressed and how the risk is to be diminished	Anticipated Risk Score After Action Plan Completed Prob Impact Score		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk		External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking				
Cluster Director of Communications and Corporate Affairs with Chief Operating Officer	Organisational statutory responsibilities are not fulfilled undermining business continuity, resilience and emergency preparedness	1	4	4	Organisational clustering to enhance resilience Business continuity plans Functions mapping and transition planning Regional emergency preparedness executive group	Functions have assigned director leads Testing of business continuity plans SHA transition plans SHA transition leads network NHS transitional resilience assurance framework	Transition assurance process Audit Commission scrutiny of transition	None identified				

Objective: 6. Effective operation during transition

c) Support SHA staff through transition

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Cluster Director of Workforce & Education	Corporate and individual capacity and capability are diminished by uncertainties arising from transition	3	4	12	<p>National and local people transition policies</p> <p>Programme of staff support to enhance personal resilience</p> <p>Internal communications policy</p>	<p>Implementation of national and local people transition policies</p> <p>SHA transition plans – focus on Human Resources and Staff Support</p> <p>Personal transition planning in conjunction with line managers – linked to annual review process</p> <p>Team briefing and regular staff briefings to ensure consistent communications</p> <p>Organisational change development programme for managers</p> <p>Establishment control process agreed for NoE</p>	<p>Audit scrutiny of transition</p> <p>Consultation with Trades Unions</p>	Lack of clarity on structure and functions of successor bodies	Outside NoE control	3	4	12

Objective: 6. Effective operation during transition

d) Ensure efficient organisational closure of the three statutory organisations (North East SHA, North West SHA and Yorkshire and the Humber SHA)

-----Risk Action-----

Current assessment of level of risk to achievement of objective – based on controls and assurances in place					Action Plan to Reduce Probability or Impact of Risk							
Lead Director	Potential Risk	Risk Level			Key Control Mechanisms	Management Assurance/Actions	Independent Assurance	Gaps in Controls or Assurance	Action Plan	Anticipated Risk Score After Action Plan Completed		
	Should be high-level potential risks that are unlikely to be fully resolved and require ongoing control	Prob Impact Score Score probability 1 (rare) to 5 (almost certain) Impact 1 (Insignif.) to 5 (catastrophic)			The systems and processes in place that mitigate this risk	What we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board	External evidence that risks are being effectively managed (e.g. planned or received audit reviews)	Where an additional system or process is needed, or evidence of effective management of the risk is lacking	How the identified gap is to be addressed and how the risk is to be diminished	Prob Impact Score		
Cluster Director of Communications & Corporate Affairs	Ineffective management of the closure of the three statutory organisations results in a loss of knowledge and undermines the effective operation of successor bodies	3	4	12	Information Governance Guidance – including Effective Management of Records during transition or organisational change Organisational handover process SHA Cluster network of leads for organisational closedown	SHA Transition Plans – include IG actions Electronic and physical file cleansing in progress Implementation of SHA Records Management policies Knowledge and information transfer incorporated into handover	Planned audit scrutiny of records management	None identified	Current capacity of internal and external IG expertise for NoE under review	3	4	12