Five Year Strategic Goals	2012/13 Corporate Objectives	Ref	Key Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Likelihood	Impact	Initial Risk Score	Controls *The systems and processes in place that mitigate the risk*	Management Assurance *What are we doing to manage the risk and how this is evidenced - how and when this will be reported to the board?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Likelihood	Impact	Residual Risk Score	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking and need improved reporting on assurances*	Action Plans *to address gaps in control/assurance*	Implementation Date	Target Risk Score
1. Delivering integrated care models across Whittington Health	1a. Collaborating with GPs, social services and other NHS providers to deliver integrated care strategy 1b. Improving data quality and developing metrices to enable real time monitoring and reporting of performance 1c. Improving communication with GPs by having electronic communication as standard and using a GP portal	1.1	If we fail to secure the support for our IBP from GPs as commissioners and primary care providers, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	GB	4	4	16	Primary Care Engagement strategy Trust Marketing Strategy Membership of Haringey and Islington Integrated Care Programme boards (focus on transforming services through integrated care) Joint NCL/WH Transformation Board workingcollaboratively with CCGs to commission service transformations Two year block contract for 2012/14	Feedback from GP practice visits Appointing a Commercial and Business Development Manager Developing Primary Care Engagement and Trust Marketing Strategy Deep dive into GP engagement by Audit Committee 13/9/12		3	4	12	Primary Care Engagement and Trust Marketing Strategy Recruitment to the Commercial and Business Development Manager Post Directory of services Implementation of GP electronic communications	Head of Performance appointment Primary care engagement strategy Trust marketing strategy Primary Care engagement and Marketing Group established by 31/10/12	31/10/2012	6
		1.2	If we do not improve the quality, completeness and timeliness of performance reports, then we may lose the support of commissioners who value more detailed data, we may be unable to correct performance issues in a timely manner and our FT application may fail.	MDS	3	3	9	Performance Manager Post responsible for dashboard development Monthly Trust Board and Divisional Dashboards CoEfficient (external consultants) development work with Information Department EPR project information workstream Implementation of Qlikview reporting tool	Evidence that monthly performance report is comprehensive and data no more than 1 month behind Deep dive into information quality by Audit Committee 7/3/12 and 13/09/2012	Audit Commission's data quality audit MQGF RMS Tenon report HDD1 Deloittes report Co-efficient review of Infomatics function	3	3	9	Implementation plan to ensure commissioners receive timely and complete performance information Information Strategy	New performance manager starting 2/10/2012 (previously 12/9/12) Infomatics team development plan Implementation of Qlikview Review of all KPIs in dashboard for organisational level appropriateness Ensure commissioners receive timely and complete performance data Timely delivery of action plans arising from external reviews - WHO monitors Information strategy Actions to improve staff compliance with mandatory IG training	31/10/2012	4
		1.3	If commissioners are unable to realise the benefits of having an ICO in the sector to control demand, our CCGs could become insolvent, then they will not be able to afford our services and the Trust will not be viable as an FT	RM	3	5	15	NCL Whittington Health Transformation Board Commissioner alignment with IBP	Performance monitoring of activity Contractual monitoring and Clinical Quality Review Group Convergence letter from NCL and CCGs		2	4	8	Influence on patient demand by GPs and provision of primary care services, and supply by other providers outside of WH control	Primary care development plans implemented by CCGs	monthly revie	8
2. Ensuring "no decision about me without me"	2a. Improving the patient experience by one quartile as measured by national patient surveys 2b. To enable 50% of all communication with patients to be sent by electronic media in 2012/13 and 75% by 2013/14 2c. Achieving 100% of discharge letters to be sent to GPs and patients within 2 working days 2d. Clinical transformation projects to put patients at the centre of their own recovery	2.1	If we lose focus on safety and patient experience at the time of cutting costs, then our main business of caring, patient safety and quality of care could be put at risk.	BS	3	4	12	All CIPs must pass quality impact assessment criteria to go forward Patient Experience strategy Transforming Patient Experience project to improve patient administrative processes Complaints and Serious Incident reports NET promoter score Nurse Rounding	Quality Committee and feeder subcommittees	CQC reviews National Patient Surveys Hospital mortality indicators (SHMIs) LINKS and Healthwatch	3	3	9	Quality Committee to keep a Clinical Risk Register		Bi-monthly review by Quality Committee	8
		2.2	If there are persistent or serious lapses in information governance, then we will be failing in our statutory obligations	RM	3	4	12	Information Governance (IG) improvement plan to meet level 2 IG toolkit compliance Implementation of IG compliant information asset owners system IG toolkit compliant IT and Network Security policy embedded within organisation Staff training and communications on IG	Senior Information Responsible Officer (SIRO) in post Caldicott Guardian in post IG function work plan to ensure compliance with IG level 2 IG Steering Gp Deep dives into IG at Audit Committee on quartely basis	Audit Commission PbR annual review Parkhill annual IG toolkit review	3	4	12		Specialist IG skills being procured to advise on priority actions Additional 1.4 wte IG resource IG improvement plan to meet level 2 IG toolkit compliance New Performance Manager to focus on achieving compliance of IG information asset owners system IT Director to develop IG toolkit compliant IT and Network Security policy Ongoing staff training and communications on IG - monitored weekly against 95% target	Progress monitoring by Audit and Risk Committee	6
3. Delivering efficient and effective services	3a. Meeting key national performance indicators, targets and standards 3b. Achieving statutory financial duties including financial targets to maintain a Monitor Risk Rating >3 3c. Delivering £13.1 m Cost Improvement Programmes (CIPs) 3d. Full implementation of Service Line Management (SLM) 3e. Achieving productivity levels equal to the peer group average as measured by the Reference Cost Index (RCI)	3.1	If we fail to engage our consultants and other staff, then we will not be able to deliver the benefits of our strategy (including CIP programmes, pathway redesign, improvements in patient admin processes)	MDS CIC BS MB	4	4	16	Staff engagement strategy includes communications, alignment meetings etc Divisional structure Implemtation of SLM Transforming Patient Experience (TPE) programme board Visible leadership at all levels	Deep Dives into staff engagement by Audit Committee 7/3/12 & 13/9/12	Staff survey indicates engagement in top 20% of trusts	3	4	12	More evidence of staff engagement and monitoring of progress Board site visits		Monthly review of KPIs by TB	6

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		3.2	If we miss our CIP targets significantly (>10%), then we may fail to meet our overall financial targets for the year, our Monitor risk rating and FT application are at risk, and we will lose the support of cour commissioners and partners	MDS	4	5	20	More robust management of CIPs CIP Programme Management Office CIP Programme Manager Improvement in accontability Board visibility through Finance and Development Committee	CIP Board monitors CIP implementation progress weekly, reporting to EC and F&D Committeee Monthly reporting to TB on CIPs Monthly Service Line reporting showing position compared to reference costs	Internal Audit reports into CIPs governance processes	4	4	16	Review and potential release of unallocated cost pressures budget Reinstatement of vacancy scrutiny panel Trust Board to have greater visibility over the risks associated with CIPs plans Project initiation documents (PIDs) required for every CIP	Develop a CIPs Risk Register that is reported monthly to the TB Update 2012/13 CIP programme with substitute schemes Fully identified CIP plans for 2013/14 and 2014/15	30/09/2012	9
		3.3	If future London-wide service reconfigurations (e.g. cancer, pathology) result in a significant amount of our activity being decommissioned, then we may not be viable as an FT	CIC	4	4	16	Benchmark our services to ensure we are as efficient as possible while maintaining high quality Ensure we meet service standards including patient experience Explore joining Pathology JV Partnership once preferred bidder is known		External service reviews e.g. cancer peer reviews, NHSL pathology reviews	3	4	12	This is an external strategic decision not within our control		ongoing	9
		3.4	If we are not able to identify sufficient detailed CIP schemes to meet our cost reduction targets from 2013/14 onwards, then we will not be viable as an FT.	MDS	4	5	20	Use of SLM and Reference Costs as benchmarks to set CIP tagrets	CIP Board monitors CIP implementation progress weekly, reporting to EC and F&D Committeee Monthly reporting to TB on CIPs Monthly Service Line reporting	HDD2 and HDD3	4	4	16	Modelling of the downside risks in top five CIPs Top 5 risks must not exceed 12% of income (£33-35m)	CIPs Plan for 2013/14 onwards IBP	30/09/2012	9
		3.5	If there is no coherent maternity strategy for NCL, then we will not be able to afford investment and patient care will suffer	CIC BS	4	4	16	Benchmarking the costs of our obstetric and midwifery services show the Trust to be more expensive than average and also have one of the lowest decile birth:midwifery ratio in the country	Sharing this information with staff to stimulate action to improve productivity	NHSL audit of maternity services CNST level 3 assesment	3	4	12	Independent expert advice on appropriate staffing and practices This is an external strategic decision not within our control	External review of midwifery practice may be required	30/12/2012	9
		3.6	If we do not fully implement Service Line Management (SLM), then consultants will not know where and how to cut costs, and both our CIP and overall financial targets will be at risk	RM	4	4	16	Structured roll out of Service Line Reporting (SLR) to clinical leads Training sessions provided for Divisional Directors, Clinical Directors and Clinical Leads on how to interpret SLR reports CLs and CDs use SLR data to reduce costs to level of RCI = 100 by 2014/15	Finance & Development Committee remit includes monitoring of SLM implementation SLM reports reviewed monthly at TB to include names of CLs Evidence of SLR data being used to inform decision making Audit Committee deep dives into SLM	Historic Due Dilligance (HDD) Stage 2 due to start 22 October 2012	3	4	12	Evidence that adequate financial support is being provided to service line CLs to achieve ownership of service line performance	Audit Committee deep dive with evidence of project plan to roll out Patient Level Information Costing (PLIC) to every consultant	30/11/2012	6
4. Improve the health of the local people	4a. Maintaining top decile safety record as measured by standarised Hospital Mortality indicator (SHMI) and other mortality indicators 4b. Operating a 7 day organisation 4c. Improving compliance with local targets including CQUINS as measured by step change in RAG ratings 4d. Meeting waiting times targets for community services, notably musculo skeletal, physiotherapy and podiatry services	4.1	If we fail to meet quality and safety standards and maintain or improve our performance in patient safety and patient experience, then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk.	CIC BS	4	3	12	Weekly monitoring of Serious Incidents by Executive Committee Patient Safety Thermometer Quality Committee and feeder subcommittees	Infection control audits and quarterly DIPC reports Patient surveys reported to Quality Committee Patient stories at TB Regular review & monitoring by Quality Committee, incl board walk-abouts	CQC reviews ECIST review visit in May 2012	3	3	9	Evidence that ECIST action plan is being implemented Appointment of an interim ECIST Programme Manager	Action plans for improvement to ED and outpatients ECIST action plan	Quarterly reviews by Quality Committee	6
		4.2	If we fail to meet CQC essential targets (KPIs) including ED and cancer waiting times, then our patients will be experiencing poor care and our CQC licence and FT application are both at risk.	MDS	4	3	12	Weekly monitoring of all KPIs, action plans and trajectories by Operations Board with escalation to Executive Committee Quality Committee	Divisional Performance Dashboards Performance report to TB Discussions at DMTs and Divisional Boards Infection control audits and quarterly DIPC reports Patient surveys reported to Quality Committee Patient stories at TB	CQC reviews National patient surveys	3	3	9	Evidence that ECIST action plan is being implemented Appointment of an interim ECIST Programme Manager Head of Performance starting 2/10/12	Performance report to TB Action plans for improvement to ED and outpatients ECIST action plan	Monthly review by TB	6
		4.3	Revenue growth will be a key element of our clinical and financial strategy, however minimal amounts are incuded within our financial plan and as such reliance upon expenditure and transformational CIP forms the risk under this heading.	RM	4	4	16	Use of detailed planning templates to back up growth proposals Engagement of CCGs in developing growth plans		Written expressions of support from CCGs for growth plans HDD1 (completed) and HDD2	3	3	9		Convergence letter from CCGs agreeing to growth plans	24/09/2012	8
		4.4	If GPs and patients do not believe that all our services are available and accesible (i.e. have short waiting times), of high quality and good value, then we may lose market share through Patient Choice	MDS	4	4	16	Focus must be to ensure that services meet the expectations of patients and commissioners notably waiting times Differentiate our services by offering care models of high quality and lower costs to become provider of choice Offer discounts to minimise loss as last resort GP Directory of services	Monitoring of market share indicates no significant losses to date		3	4	12	Feedback from GPs indicates that WH is at risk of losing market share to neighbouring Trusts which have shorter waiting times and are developing more accessible services e.g. direct telephone calls to consultants	Pathway redesigns have to produce better quality services at lower costs, that will allow the Trust to be the preferred provider for local GPs	Review by F&D committee	8

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5. Fostering a culture of innovation and improvement	5a. Adoption of an innovation Strategy 5b. Achieving Foundation Trust Accountability Agreement milestones 5c. Delivering service transformation as set out in QIPP programme 5d. Adoption of LEAN across the Trust and meeting Unipart project milestones 5e. Implementation of workforce and staff engageme	5.1	If the FT programme is not well planned and managed, then we may miss our TFA deadlines and fail our FT application If our Integrated Business Plan (IBP) is not underpinned by a robust Long Term Financial Model (LTFM), our FT application will fail	RM	3	4	12	FT programme plan Monitoring of progress by FT Programme Steering Group	FT Programme reports Self assessments Progress update on action plan	Internal Audit report on FT programme External Audit report MQGF report by RMS Tenon BGAF by E&Y Working capital by KPMG	3	3	9	FT programme manager to maintain an FT Risk Register that is presented monthly to the TB TB to ensure the risks within the IBP map to the BAF or Corporate Risk Register with an escalation process Integrated risk management system to be implemented asap	Action plans developed in response to all external review reports All risks identifed within the IBP to be modelled in full and FT Risk Register to be presented to the TB monthly	Monthly review by TB	8
		5.2	If we are unable to fully implement our workforce strategies (e.g. for efficiency, engagement, skill mix), then we will not be able to deliver cost savings or service transformation and will not be viable as an FT. Management capacity is stretched and unsustainable for longer than the short term.	MDS CIC BS MB	4	5	20	Workforce strategies including Nursing, Midwifery and AHP strategy Staff engagement strategies Benchmarking and use of RCI to set productivity targets by service lines raise financial awareness among staff Participation in NHSL productivity improvem	Monitoring of workforce statistics	Annual staff survey	4	5	20	Evidence of staff engagement strategies being implemented Additional management capacity required especially to support implementation Independent assurance that workforce plans are fit for purpose Feedback from staff consultations on organisational change	To seek external support on workforce and organisational development plans Review of management capacity	Quarterly Review by Audit & Risk Committee	12
		5.3	If the quality of teaching is not excellent, then commissioners (UCL, Middlesex and LETBE) may not renew their teaching contracts. This will not only lead to a loss in income, it may lead to loss of trainees who are a critical part of service delivery.	CIC	3	3	9	Prograduate Medical Education Board chaired by Director of Education oversees the quality of training Feedback to consultants on teaching quality	Ensure that consultants' job plans include teaching	External reviews by the Deanery and Royal Colleages Annual GMC survey of trainees	3	3	9	Transition from Deanery to LETBE		Annual report to TB	6
		5.4	If we do not continue to improve the uptake of mandatory training, then we are in breach of our corporate responsibility as an employer, we are at risk of litigation should accidents happen, our patient care may suffer and our FT application may fail	CIC	5	3	15	Personalised e-mail reminders are sent to staff on outstanding training requirements Message to all staff that individual performance on mandatory training will be included in appraisal discussion Divisional Directors to not agree pay thresholds if mandatory training not completed and no clear reason given Monitoring of uptake by TOB	Training compliance reports to Quality Committee Monthly performance report to TB Deep dive by Audit Committee 12/1/12		4	4	16	Mandatory Training Policy is not being implemented consistently Data quality from ESR is unreliable	Individual and peer comparison feedback to staff in leadership roles. Move to weekly updates of mandatory training compliance on intranet.		9