Strategic Goal	Corporate/Principle Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Unmitigated risk rating - Feb 2013			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)*	Current risk rating			Gaps		Due Date
			Likelihood	Impact	Initial Risk Score				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*	
1. Integrate models of care and pathways to meet patient needs	If we fail to secure support for our IBP from our commissioners, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	YMK	4	4	16	1. Partnership Transformation Board meets monthly and includes senior leaders from Haringey and Islington CCGs. 2. CCGs actively involved in shaping the IBP. 3. Informal contacts with CCGs by exec and non-exec members of TB	1. Status of engagement with CCGs and leaders regularly reported to the TB by CEO, Director of Planning, DoF etc.	1. CCG Convergence letter signed by CCGs Feb 2013. 2. Two year block contract with commissioners extends through 2013/14	3	4	12	Metrics to track implementation of the IBP need to be signed off with CCGs and reported on quarterly	Agreement of 13/14 objectives with CCGs by end March 2013	Apr-13
	If we fail to maintain ongoing support from GPs as primary care providers and sources of referrals, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	GB	4	4	16	1. Regular two way communication with GPs - led by Medical Director for Integrated Care (MDIC), who is himself a local GP. 2. Involvement of GPs in Integrated Care MDTs	1. Feedback from GP practice visits by CEO and MDIC. 2. Regular reporting of quality of services of particular concern to GPs (e.g. direct access acute services; and community services such as MSK, podiatry). 3. Audit Committee deep dive into GP engagement, Sep 2012	1. Periodic monitoring of GP referral patterns	3	4	12	A comprehensive primary care engagement strategy that prioritises GP practices and sets more detailed objectives for each	1. Develop primary care strategy. 2. Recruit business development manager by Mar 2013. 3. Complete GP directory of services. 4. Implementat GP electronic communication	Apr-13
	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.	BS/MdS/RM	3	3	9	1. Performance manager in post from 3/9/2012.	1. Monthly trust board and and divisional dashboards generally report one month in arrears.	1. Periodic internal and external audit reports on data quality are generall satisfactory. 2. Various external reports in 2012 - HDD1&2, BGAF	3	3	9	Evidence that Commissioners are satisfied with detail provided in performance reports		Monthly report to NCL& CCGs.
	If commissioners choose to market test services in order to improve affordability of services, services may be priced at a lower level or decommissioned.	RM	4	5	20	1. Two year block contract provides a control through 2013/14. 2. In the longer term, our strategy to be the low cost/high quality provider will enable us to provide competitive services. 3. Close engagement with local CCGs and GPs (see risk 1.1) enables us to be more responsive to	Periodic reports from CEO, MDIC etc following interactions with GPs and CCGs	Periodic tracking of referral patterns and market share	2	4	8	Evidence that our services are competitive or better on quality and cost	1. Recruitment of Business Development manager 2. Deep dive by Finance and Development Committee	May-13
	If we do not engage our stakeholders in the development and decisions about our strategies, confidence in our strategic direction will be undermined and our clinical and organisational reputation will be damaged.	YMK	3	5	15	1. Communication and engagement plan	1. Status of engagement with stakeholders regularly reported to the TB by Chairman and CEO etc.	1. Feedback from stakeholders	2	5	10	1. Refresh communication and engagement strategy based on 13/14 annual plan	1. Refresh under development 2. Reporting to FT committee	Mar-13
2. Ensuring "no decision about me without me"	If we lose focus on safety and patient experience, then our main business of caring, patient safety and quality of care could be put at risk.	BS	3	4	12	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns - e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality (see above).	1. Quality Committee reports regularly to the TB and assesses effectiveness of all quality-related controls through, e.g. review of clinical audits, scrutiny of Divisional boards, personal Quality Walk Rounds etc. 2. Quality Committee reviews leading & lagging indicators of quality performance - e.g. complaints, incidents, Friends & Family scores, GP surveys, emergency readmission rates, workforce statistics. 3. Quality Committee and TB have conducted 'deep dives' into known or potential quality risk areas - e.g. Emergency Dept, pressure ulcers,	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts	3	3	9	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	Monthly review of KPIs by TB. Quarterly patient safety reports to quality committee
	If there is non compliance with information governance Toolkit requirements this would adversely affect CQC assessment, FT application requirements and we will be failing in our statutory obligations	RM	3	4	12	1. IG Steering Group in place since Nov 2011. 2. Clear responsibilities flowing from SIRO and Caldicott Guardian. 3. IG issues log and risk register monitored regularly	1. Audit & Risk committee oversees IG Steering Group and also conducted a deep dive on IG risks in 2012.	1. Parkhill review of IG in July 2012 gave limited assurance. 2.External Audit report on reliability of PbR data in 2011/12 indicated improvement in coding accuracy since prior year.3. Decisoin by Information Commissioner about two Sis involving data loss on 20.11.2012	3	4	12	1. IG Toolkit compliance unsatisfactory in 2011/12. 2. Insufficient managed records storage facility on site.	Records management project established with P&P project management input. Reporting to Information Governance Committee	Mar-13
3. Delivering efficient and effective services	If we fail to maintain staff engagement then staff morale will decrease and the delivery of changes in services and patient pathways will not happen in line with the plan	All	4	4	16	1. Staff engagement strategy includes communications, alignment meetings, visible leadership at all levels 2. Clear commitment to clinical leadership at service line level. 3. Strengthened processes forcompliance with mandatory training. 4. Partnership Group meetings	Deep dives into staff engagement at audit committee 7/3/12 and 13/9/12	NHS 2011 staff survey showed engagement levels are in top 20% of trusts nationally	3	4	12	More evidence of staff engagement and monitoring of progress. Board site visits. Key assurance indicators to be developed	Quality committee members undertaking visits to divisions bimonthly commencing in October 2012. Quality Committee will receive feedback reports from visits at each bimonthly meeting. Patient Safety Walkabout programme revised and approved by Quality Committee September 2012.	Monthly review of KPIs by TB. Quarterly patient safety
	If we fail to deliver CIPs and planned productvity improvements, then our financial stability will reduce, our FT applcation will be jeopardised and local patient services may be put at risk.	MdS	4	5	20	1. CIP Board monitors CIP implementation. 2. Programme Management Office (PMO) provides operational support. 3. Contingency plans include vacancy scrutiny panel, substitution of alternative CIPs etc	1. Monthly Finance report to TB shows progress against plan. 2. Finance and Development Committee regularly reviews CIP plans for current and future years for deliverability	1. Internal Audit review of CIP programme management. 2. External review of CIPs through HDD2.	3	4	12			Mar-13
	If potential future London-wide service reconfigurations (e.g. colorectal, interventional radiology & vascular surgery, pathology) are implemented, then a significant amount of our activity being decommissioned	MK	5	3	15	1. Active engagement with opinion leaders, local providers and other stakeholders by Medical Director and CEO.2. Contingency plans developed.	Report to Audit Committee Jan 2013	External service reviews e.g. cancer peer reviews, NHSL pathology reviews	3	4	12	Further detailing of contingency plans	Audit Committee Deep Dive schedule	Apr-13
	If we do not mitigate against potential quality impacts of cost reduction programmes, then patient experience may reduce, patients may choose other providers, the Trust will lose business and the Trust's viability will be put at risk.	Mk/BS	3	4	16	1. All CIP programmes must pass clinically-led Quality Impact Assessment before going forward. 2. Clinical Advisory Group (chaired by Medical Director and Director of Nursing) monitor and report on quality impact of CIPs.3. Divisional Boards are responsible for assessing all quality risks in the division and for implementing mitigating actions	1. Quality committee and TB regularly review measures of quality, including: Complaints, Incident reporting, Friends & Family scores, GP surveys, Readmission rates, Mortality etc 2. TB monitors staffing ratios (e.g. nursing & midwifery) against good practice standards. 5. NHSLA Level 1 completed Feb 2012	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts.	3	3	9	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	NHSLA Level 2 action plan targets mock assessment in June 2013, formal assessment by Dec 2013	Monthly review
	If WH does not improve the environment and efficiency of the maternity department, then the service may not continue to be financially viable or clinically safe.	YMK	3	4	12	1. Quality of patient care and experience is monitored as in all departments through patient feedback, complaints, incident reports etc. 2. Funds now secured for substantial upgrade of maternity environment, through combination of Estates Strategy and NHS grant award.	1. Estates strategy was approved by TB In Jan 2013. 2. Performance of maternity is subject of regular reviews by Quality Committee 3. Maternity redevelopment plan in development		3	4	12			
	If we do not fully implement Service Line Management (SLM), then consultants will not know where and how to improve efficiency, weakening their clinical leadership in the achievement of CIPs and financial trajectories	RM/MdS	3	5	15	Structured roll out of SLR to clinical leads, training provided by divisional directors, clinical directors and clinical leads on how to interpret reports. CLs and CDs use SLR data to reduce cost level pf RCI = 100 by 2014/15	1. Finance & Development committee remit includes monitoring of SLM implementation. 2. SLM reports reviewed monthly at TB, to include names of CLs. 3. Evidence of SLR data being being used to inform decision making. 4. Audit committee deep dive in SLM.	HDD2 in Nov 2012 noted that WH continues to implement SLM across the Trust	3	4	12	Evidence that adequate financial support is being provided to service lineCLs to achieve ownership of service line performance. Key assurance indicators to be developed	Audit committee deep dive with evidence of project plan to roll out Patient level Infotrmation Costing (PLIC) to every consultant.	Quarterly report to TB
	If a Tariff deflation proves to be greater than in our plans, then this will reduce WH income and may affect its financial viability	RM	4	5	20	1. Block contract provides security through 2013/14. 2. In the longer term, our strategy mitigates some of this risk through growth in additional services and with other commissioners.	LTFM assumptions and associated risks periodically reviewed by F&D Committee		3	5	15	1. E&Y review of LTFM commissioned Feb 2013.		Monthly review through 13/14 financial
	If payroll related costs including severance are higher than planned this will cause financial instability against financial plans	RM	4	4	16	1. Our plans are to take advantage of existing vacancies and natural staff turnover (which combined are substantially in excess of envisaged workforce reductions over the next 5 years) to minimise redundancies	LTFM assumptions and associated risks periodically reviewed by F&D Committee		3	3	9	1. E&Y review of LTFM commissioned Feb 2013.		Monthly review through 13/14 financial

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4. Improve the health of local people	If we fail to meet quality and safety standards including CQC essential targets, along with waiting times for ED, cancer, MSK and podiatry, then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk.	MK/BS/MdS	3	5	15	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns - e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality (see above).	1. Quality Committee reports regularly to the TB and assesses effectiveness of all quality-related controls through, e.g. review of clinical audits, scrutiny of Divisional boards, personal Quality Walk Rounds etc. 2. Quality Committee reviews leading & lagging indicators of quality performance - e.g. complaints, incidents, Friends & Family scores, GP surveys, emergency readmission rates, workforce statistics. 3. Quality Committee and TB have conducted 'deep dives' into known or potential quality risk areas - e.g. Emergency Dept, pressure ulcers,	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts	4	3	12	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	NHSLA Level 2 action plan targets mock assessment in June 2013, formal assessment by Dec 2013	Monthly review
5. Fostering a culture of innovation and improvement	If the FT programme is not well planned and managed, then we may miss our deadlines and fail our FT application	YMK	4	5	20	1. Refreshed and stronger Board now in place, with capabilities and governance processes to lead an FT. 2. Integrated care organisation now in place, well placed to deliver its strategic vision. 3. Partnerships with Commissioners and other healthcare providers provide support for the implementation of our strategic vision. 4.	1. FT Board provides scrutiny of programme management. 2. Status of FT application is standing item on TB agenda	1.Internal audit on FT programme. 2. MQGF report by RMS Tenon 3. BGAF by E&Y. 4. HDD 1 & 2 by Deloitte. 5. Working capital by KPMG	2	5	10	1. NHS London B2B February 2013		Monthly review by TB
	If management capacity for change leadership is too stretched, transformation in the way services are provided and managed will not be achieved	YMK/MdS	3	4	12	1. Ongoing commitment to increase capacity by delegating leadership to lower levels in the organisation - e.g. creation of 3 Divisions, appointment of Service Line Clinical Leads etc.2. Regular monitoring of management capacity & capability through appraisals, 360° feedback, Board development programme, and external feedback via FT process. 3. Selective strengthening of management capacity from external sources - e.g. Interim OD Director; E&Y	1. Change leadership capacity discussed in Board Seminars. 2. Informal NED discussions on leadership capbility & capacity	1. BGAF report. 2. Informal discussions with other external stakeholders who know us well (e.g. NCL, NHSL, CCGs)	3	4	12	1. Ongoing objective to raise capability of Board members and other senior leaders. 2. Additional management capacity still required in selected areas	Monthly board development programme	TB BGAF Annual review June 2013
	If we do not implement an effective OD strategy, we will fail to evolve / employ / train our work-force to deliver service changes and productivity improvements and therefore CIP will not be delivered, services will not be transformed safely and our FT application will be significantly jeopardised.	BS/MB/MK	4	5	20	1. Continued development of integrated training & education programme, focused on skills relevant to the Trust's strategy. 2. Processes to maximise compliance with mandatory training. 3. Ongoing Board and other leadership development programmes. 4. Continued reinforcement of a culture that encourages mentoring, continuous improvement, and innovation. 5. Appointment of Interim Director of OD, Feb 2013	1. TB regularly reviews workforce statistics, incl training, appraisals, sick leave, vacancies etc. Interim OD Director hired Feb 2013	1. NHS 2011 workforce survey shows WH in top 20% of trusts nationally for: training, engagement, teamwork	3	4	12	1. Refinement of OD strategy and associated programmes. 2. Appraisals and job planning. 3. Leadership development - e.g. for clinicians to become effective service line leaders	External support on workforce and organisational development plans from Nov '12. Interim OD Director hired Feb 2013	Quarterly review by Audit and Risk committee
	If the quality of teaching is not excellent, then commissioners (UCL, Middlesex and LETB) 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.	MK/BS	3	3	9	1. Post graduate medical education board chaired by Director of Education oversees quality of training. 2. Director of UCL Medical School is a NED on the Trust Board. 3.Commitment to maintain/enhance training infrastructure evidenced by TB 3. approval of capital expenditure for e.g. Library, Cinical Skills Centre		1. External review by deanery and Royal colleges. 2. Annual GMC survey of trainees	3	3	9	Transition from Deanery to LETB Key assurance indicators to be developed		Annual Report to TB