Paper NHSE130910

BOARD PAPER - NHS ENGLAND

Title: Performance report
Clearance: Tim Kelsey
Purpose of paper: • To provide the second report on NHS England performance, focusing on the delivery of the Business Plan, *Putting Patients First.*
Key issues and recommendations: This is the second comprehensive report to the NHS England Board. This report takes the NHS England Business Plan as its starting point and tracks progress against both the 11-Point Scorecard and the actions and deliverables set out in that Plan. As more data has become available since the first report and will continue to do so, the Board is asked to consider both the format and contents of this report to assist in the design of subsequent updates.
Actions required by Board Members: • To agree any changes to the format and contents of future reports; and • To agree any actions arising from the contents of this report.

Performance report

Summary

1. This is the second report to the NHS England Board setting out progress against the business plan, *Putting Patients First*, and more fundamentally, against our key objective of high quality care for all, now and for future generations.

Putting Patients First: The NHS England business plan for 2013/2014 – 2015/2016

2. Building on the planning guidance for commissioners, *Everyone Counts: Planning for Patients 2013/2014*, the NHS England Business Plan set out in detail how we will support commissioners to use their valuable public resources to improve quality and secure the best possible outcomes for people.

3. The plan also affirmed our commitment to transparency and set out how we will assess our own progress and be accountable for our actions. In particular, it set out a new 11-Point scorecard reflecting our core priorities against which we will measure performance and as with the first report, the scorecard forms a key element of this report. In addition, the business plan provided details of NHS England's operating model and explained how we will deliver our mandate from the government and fulfil our duty to improve outcomes for people. This report also covers the actions we committed to in the Business Plan.

Contents and coverage

4. On 1 April 2013, NHS England took on its full range of new powers and this is the second report to the NHS England Board in its new form. The table below sets out the main sections of the Board report, with this paper providing the summary narrative around the report.

Board report attachments

Section	Attachment
A. The 11-Point Scorecard	Indicators in the 11-Point scorecard for which we have data for the period after 1 April 2013. Data is not available across the entire 11-Point Scorecard but is a significant increase over that available in the first report.
B. Business Plan deliverables	Covering the actions due for delivery from 1 April to 2 August 2013.
C. NHS Performance and Finance	Further detail on current NHS performance and finance, focusing on recent performance and any issues arising.
D. Organisational Health	Further detail on the organisational health of NHS England, including an analysis of complaints received by NHS England since 1 April.
E. Historic data and Placeholders on the 11-Point scorecard	For some of the 11-Point scorecard we only have data referring to periods before April 2013. For information, this data is shown here alongside areas where new data collections are in train but not yet available.

5. The Board assurance framework was discussed at the executive risk management group on 29 August and is also included here as Annex F.

Key issues in this Report

6. This September report marks a significant increase in the performance data available on the 11-Point scorecard. In particular we add for the first time the friends and family test, cancer waiting times, the NHS England staff barometer and the full suite of finance data. However, it remains the case that most health outcomes data is not yet available for the post 1 April 2013 period and remains in section E (historic data pre-dating NHS England). We have initiated discussions to access early provisional data on these areas and aim to add greater richness on outcome data in later reports.

7. In addition, section C, which provides more granular information on current NHS performance now includes information on the distribution of performance across commissioners and providers as well as overall national performance.

8. Across the 11-Point scorecard metrics, all indicators that have been given a rating (Red-Amber-Green) are `green' except for:

- four indicators with extremely challenging operational standards: MRSA, patients waiting over 52 weeks for treatment, Mixed Sex Accommodation breaches and re-booking of cancelled operations. These set standards of either zero (the first 3) or 100% (the last); and
- four Amber rated Finance indicators, three of which relate to Direct Commissioning. Para 30 below sets out the issue.

Friends and Family Test (FFT)

9. The 11-Point Scorecard set the FFT as one of the key overarching indicators of NHS England performance and this will now be part of routine reporting to the Board, contained in Section A. For this report this includes the first set of data for the acute inpatients and A&E services and the FFT for maternity services is on track for October 2013. A publication on the top tips for implementing FFT and gaining good response rates has also been issued.

Urgent Care: A&E, Ambulances and NHS 111

10. The NHS is committed to provide patients with convenient, easy access to services within a maximum waiting time set out in the NHS Constitution. For A&E, the pledge to patients is a maximum four-hour wait in A&E from arrival to admission, transfer or discharge. The operational standard by which we judge success is that 95% patients should have a maximum wait of four hours because there are some patients where there may be clinical reasons for them to remain longer in A&E. This is a key measure for patients and the NHS makes every effort to ensure that patients wait no longer than necessary.

11. After a period ending April 2013 when the A&E standard was not achieved, the standard is currently met in aggregate across the country. Under the NHS

A&E Improvement plan we have a comprehensive programme of work with the NHS and our partners to address on-going sustainability of issues, and to prepare for the additional pressures of the winter months.

12. The NHS England A&E Improvement plan has resulted in the following actions to improve sustained delivery of the A&E standard going forward:

- System Recovery and Improvement Plans (SRIPs), covering every A&E unit to recover and sustain delivery;
- Established urgent care boards representing the entire local urgent care system to coordinate actions and drive improvements in line with SRIPs; and
- National and regional tripartite groups (NHS England, NHS TDA, Monitor with the association of directors of social services) providing oversight and challenge to systems to assure plans for delivery.

13. Another key group of pledges under the NHS Constitution are those around ambulance response times to ensure ambulances respond to 75 per cent of red emergency calls (the most serious and life threatening) calls within eight minutes and 95 per cent of other calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

Elective Care, 18 weeks referral to treatment times

14. The NHS Constitution includes the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. This is an important right for patients because it means that patients are seen quickly. The right is measured by performance against the three operational standards such that 90% of patients on an admitted pathway are treated in 18 weeks; 95% of non-admitted pathways are treated in 18 weeks; and 92% of those on incomplete pathways should have been waiting less than 18 weeks. Performance against these standards is broadly stable.

Waiting Time for Patients with Suspected and actual Cancer

15. Prompt treatment for cancer patients is important for their clinical outcomes and for their own peace of mind. The NHS Constitution includes a right and a number of pledges on cancer waits to ensure that patients are treated promptly. They include the right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected; and maximum waits for initial referral and treatment and subsequent referral and treatment. Across the country all the cancer waits operational standards are being met.

Waiting Times for Diagnostic Tests

16. Prompt access to diagnostics, is another important aspect of access for patients so that they can quickly know what is wrong and the NHS constitution includes a pledge that patients waiting for a diagnostic test should have been

waiting less than 6 weeks from referral. This pledge has an operational standard of 99% and currently the NHS is meeting this standard.

Business Plan actions and deliverables

17. One deliverable has been completed during the 10 June to 2 August period. This was the publication of a range of tools and resources aimed at supporting the nursing contribution to the dementia challenge. This is part of the wider delivery of the nursing strategy, Compassion in Practice.

Other key achievements including part delivery of business plan deliverables

18. To support the delivery of the 10 year strategy, our 'Call to Action' was published on 11 July 2013. This starts the engagement with staff, the public and politicians on the future shape of the NHS.

19. The high level principles from the Urgent and emergency care review were published in June 2013. A consultation is now underway and this will support the development of the long term solutions which will form part of the 'call to action' engagement plan.

20. The plan for shingles vaccination for 70 year olds was published on 12 July 2013. The tripartite flu immunisation programme for 2013/2014 was published on 26 July 2013.

21. The work underway to launch a public facing multi-channel customer response service spanning health and social care, via a customer services platform called 'Health and Social Care Digital Services' is at a critical stage. Complex processes around approvals and procurement have the potential to cause some delays. Collaborative work is on-going between NHS England, Department of Health and the Health and Social Care Information Centre to refine processes.

22. Work relating to 2013/2014 contracts and payments for the Commissioning for Quality and Innovation (CQUIN) framework that rewards providers for improving dementia care is complete. Work is now focusing on commitments for 2014/2015.

23. Work continues to progress within the Leadership Academy, who are on track to deliver core programmes to 2000 staff by April 2014. Applications have been assessed and cohort places have been allocated. NHS employer organisations have been informed of decisions and private sector uptake of programme places is good.

24. NHS England has agreed a process for carrying out 360 degree feedback from staff, clinical commissioners, the public and key partners. The review will include a staff barometer, of which the first results have already been published, a survey to all 211 CCGs, and feedback from patient/public representative groups and key national partners. Four directorates are

involved in this work, each taking a lead on a focus area.

25. As part of NHS England's oversight and leadership of the commissioning system, work is progressing well to ensure robust planning and financial management within CCGs. Final QIPP plans with CCGs have now been agreed and the financial performance of all commissioners will be monitored and risk assessed throughout the year. In addition, to support oversight and leadership of the commissioning system, the CCG assurance process commenced on 18 July and runs through to 30 September.

26. The review of the NHS allocations methodology will influence the 2014/2015 and 2015/2016 allocation process. The initial findings from the review will be available in November 2013 instead of September as expected. This will allow for important feedback from NHS commissioners gathered during a series of summer/autumn engagement workshops and it is anticipated that this will not affect the production of the NHS allocations by December 2013.

Other deliverables

27. NHS England produced and published single operating models for directly commissioning services prior to April 2013, but embedding is not yet complete. They will be embedded via the area teams with work on implementation included in their 2013/2014 plans. The directly commissioned services committee will oversee the implementation of the direct commissioning strategic priorities as agreed by NHS England Board plus deliver leadership and direction to the implementation of the single operating models for directly commissioned services.

28. Good progress had been made in the development of supporting documents for the choice and competition framework with documents going through internal governance processes for approval within NHS England and Monitor. However, Monitor is reconsidering the content and publication is being reviewed. Publication is unlikely to be before late Autumn 2013.

Finance month four

29. Since month 3 the year to date actual and full year forecast position has been reported and discussed in detail at the monthly Operations Executive and Finance and Investment Committees. The only remaining significant gap in the detailed finance report is activity information. For the four months to the end of July 2013 the high level position is set out below.

30. The year to date and full year forecast position is summarised in the Table below with the key features:

a) The positive Month four year to date position, £91m better than plan, is wholly driven by underspends on the £965m central programme budget, which will largely reverse in subsequent months.
b) There are no major unanticipated adverse issues highlighted by CCGs in aggregate.

c) The adverse position in direct commissioning year to date and full year forecast mainly relates to specialised commissioning.
d) The availability of robust activity information on which to base accruals for actual hospital costs and to identify trends for forecasting the balance of year remains a significant issue. As a consequence, there is a significant degree of estimation in the reported year to date spend and full year forecast across CCG and specialised commissioning. In particular, six out of 10 area teams have reported specialised year to date and full year forecast on plan, as they do not have reliable activity information. The activity reporting programme is urgently taking forward work in this area.

	Month 4 year to date surplus				Full year forecast surplus/(deficit)			
	Plan £m	Actual £m	Variance £m	Variance as % allocation	Plan £m	Actual £m	Variance £m	Variance as % allocation
CCGs	212.9	207.5	-5.4	0.0%	615.0	598.3	-16.7	0.0%
Transfer to LAs for social care	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%
Direct commissioning	73.6	50.9	-22.7	-0.3%	214.8	151.3	-63.5	-0.2%
Other	0.0	119.4	119.4	18.8%	-296.0	-296.0	0.0	0.0%
	286.5	377.8	91.3	0.4%	533.8	453.6	-80.2	-0.1%

Note: the variance as a % of allocation refers to the variance against planned surplus amount (i.e. plan-actual) taken as a proportion of the year to date or full year allocation (as appropriate).

31. The centrally assessed full year net risk is broadly neutral compared to planned surplus across the £95.6m Mandate spend. There remains a significant imbalance of risk between CCGs and direct commissioning, and of mitigations between recurrent and non-recurrent sources. This is broadly comparable to the sum of the net risk assessments provided by each individual CCG and area team.

Conclusion

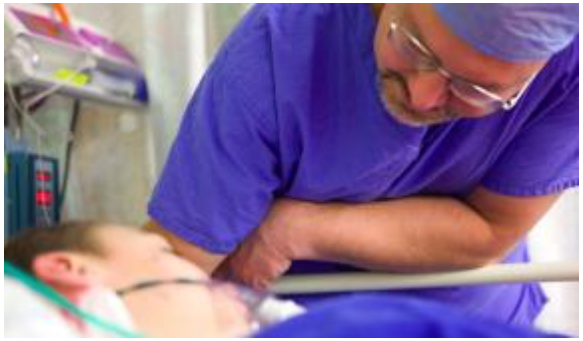
32. This is the second report to the NHS England Board on performance against the business plan. The Board is invited to:

- To agree any changes to the format and contents of future reports; and
- To agree any actions arising from the contents of this report.

Tim Kelsey
National Director for Patients and Information
September 2013

Item

Section A: The 11-Point Scorecard



NHS England Board Report
September 2013

THE NHS CONSTITUTION
the NHS belongs to us all

Priority 1 - Satisfied Patients

NHS Outcomes Framework, indicator 4c: Friends and Family Test

Inpatient FFT

Period	Apr-13	May-13	Jun-13
FFT Score	71	72	72
No. Responses	73,671	87,102	93,466
Response Rate	21.7%	24.4%	27.1%

Desired direction: Up

A&E FFT

Period	Apr-13	May-13	Jun-13
FFT Score	49	55	54
No. Responses	38,988	53,184	71,643
Response Rate	5.6%	7.5%	10.3%

Desired direction: Up

Unified Response Rate

Period	Apr-13	May-13	Jun-13
Response Rate	10.9%	13.2%	15.9%

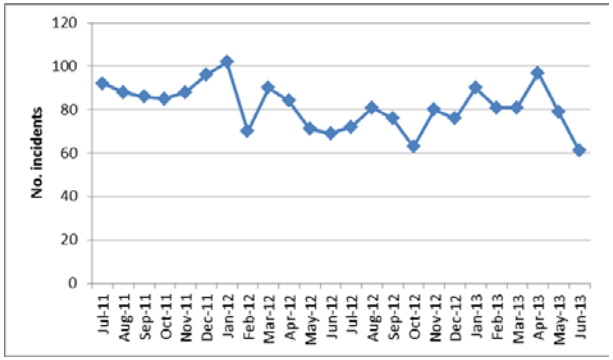
Desired direction: Up

Priority 7: Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Outcomes Framework, Indicator 5.2.i: Incidence of MRSA

		No. incidents	% Change	Direction	RAG Colour
Current Value	Jun-13	61			Red
Change on previous year	Jun-12	-8	-11.59%	↓	
Long term change	Apr-11	-52	-46.02%	↓	

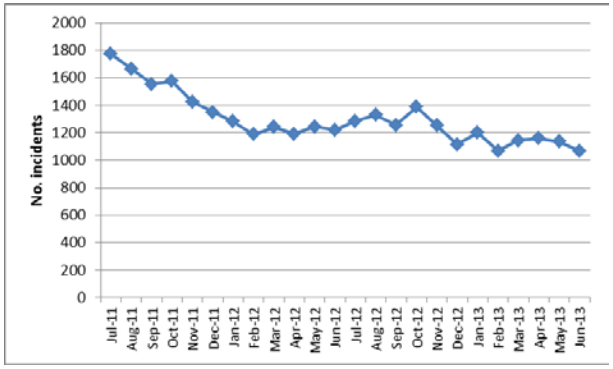
RAG based on comparison to Operational Standard of 0



NHS Outcomes Framework, Indicator 5.2.ii: Incidence of C Difficile

		No. incidents	% Change	Direction	RAG Colour
Current Value	Jun-13	1067			
Change on previous year	Jun-12	-153	-12.54%	↓	Green
Long term change	Apr-11	-499	-31.86%	↓	Green

Desired direction: Down
RAG Rating based on changes +/- 1% from previous period

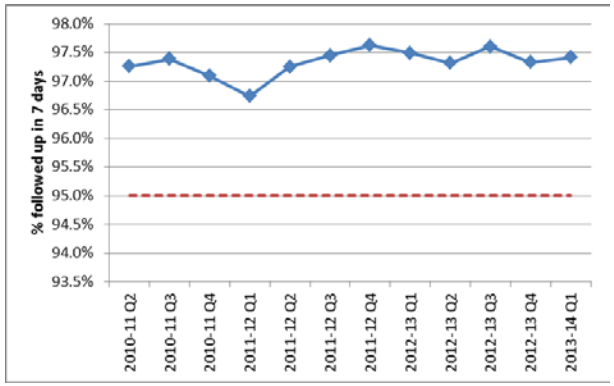


Priority 9 - NHS Constitution rights and pledges

% of patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient care

		% followed up in 7 days	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	97.4%			Green
Change on previous year	2012-13 Q1	-0.1%	-0.08%	↓	
Long term change	2010-11 Q1	0.2%	0.25%	↑	

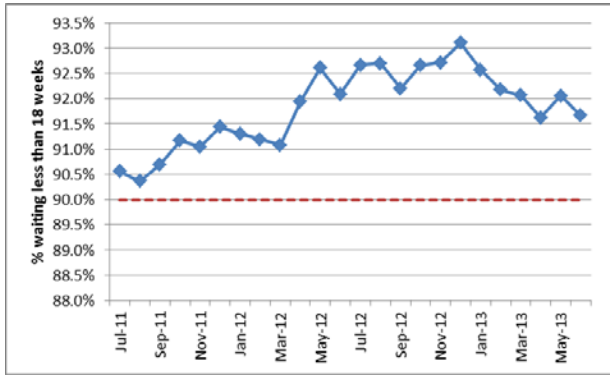
RAG based on comparison to Operational Standard of 95%



Admitted patients to start treatment within a maximum of 18 weeks from referral

		% waiting less than 18 weeks	% Change	Direction	RAG Colour
Current Value	Jun-13	91.7%			Green
Change on previous year	Jun-12	-0.4%	-0.46%	↓	
Long term change	Mar-08	4.6%	5.24%	↑	

RAG based on comparison to Operational Standard of 90%.

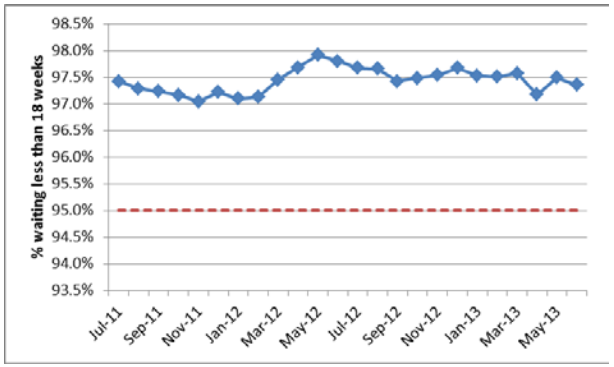


Priority 9 - NHS Constitution rights and pledges

Non-admitted patients to start treatment within a maximum of 18 weeks from referral

		% waiting less than 18 weeks	% Change	Direction	RAG Colour
Current Value	Jun-13	97.4%			Green
Change on previous year	Jun-12	-0.5%	-0.46%	↓	
Long term change	Aug-07	21.2%	27.86%	↑	

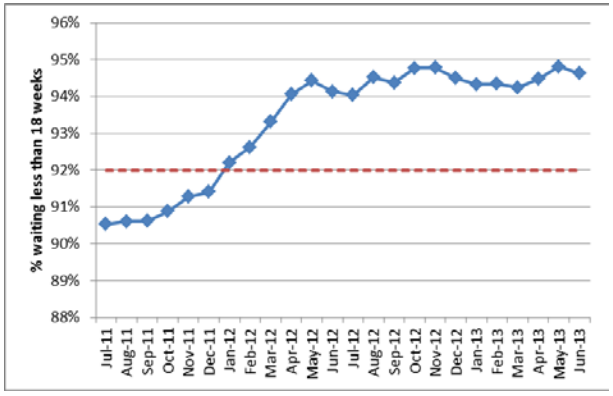
RAG based on comparison to Operational Standard of 95%.



Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral

		% waiting less than 18 weeks	% Change	Direction	RAG Colour
Current Value	Jun-13	94.6%			Green
Change on previous year	Jun-12	0.5%	0.52%	↑	
Long term change	Aug-07	37.4%	65.39%	↑	

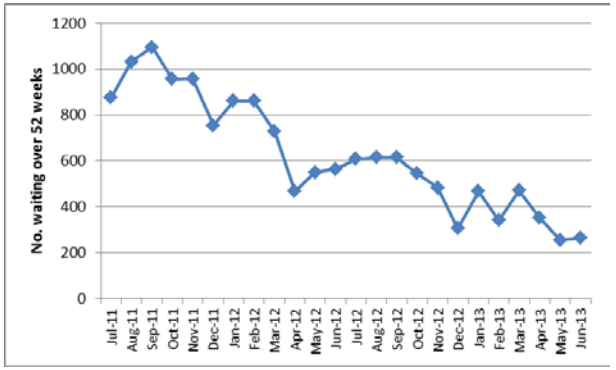
RAG based on comparison to Operational Standard of 92%.



Priority 9 - NHS Constitution rights and pledges

Number of patients waiting more than 52 weeks

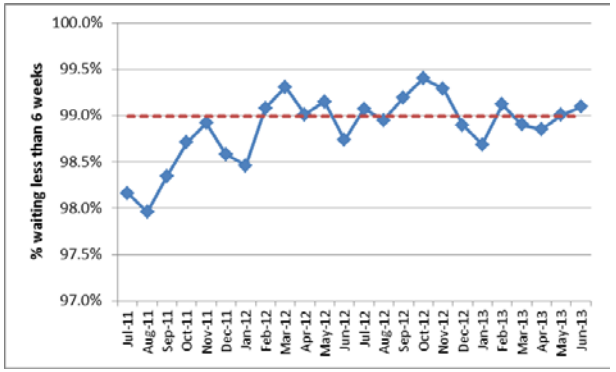
		No. waiting over 52 weeks	% Change	Direction	RAG Colour
Current Value	Jun-13	263			
Change on previous year	Jun-12	-300	-53.29%	↓	Red
Long term change	Apr-07	-20906	-98.76%	↓	Red



RAG based on comparison to Operational Standard of 0%

Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral

		% waiting less than 6 weeks	% Change	Direction	RAG Colour
Current Value	Jun-13	99.1%			Green
Change on previous year	Jun-12	0.4%	0.36%	↑	
Long term change	Jan-06	53.9%	119.46%	↑	



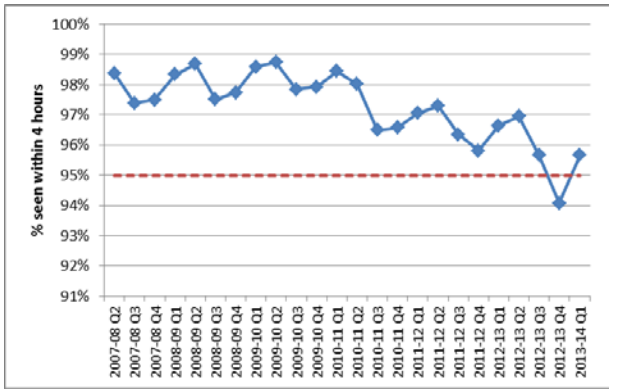
RAG based on comparison to Operational Standard of 99%

Priority 9 - NHS Constitution rights and pledges

Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department

		% seen within 4 hours	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	95.7%			Green
Change on previous year	2012-13 Q1	-1.0%	-1.02%	↓	
Long term change	2004-05 Q1	0.9%	1.00%	↑	

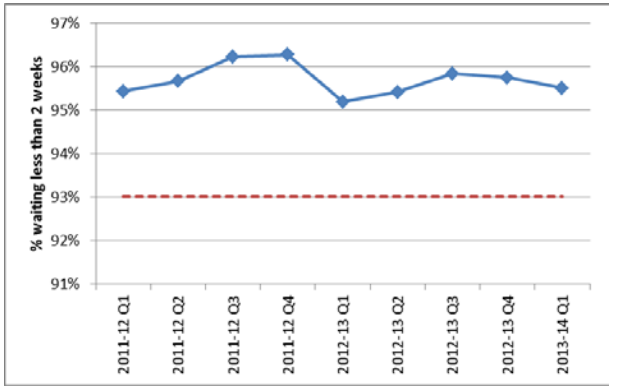
RAG based on comparison to Operational Standard of 95%



Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP

		% waiting less than 2 weeks	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	95.5%			Green
Change on previous year	2012-13 Q1	0.3%	0.33%	↑	
Long term change	2011-12 Q1	0.1%	0.08%	↑	

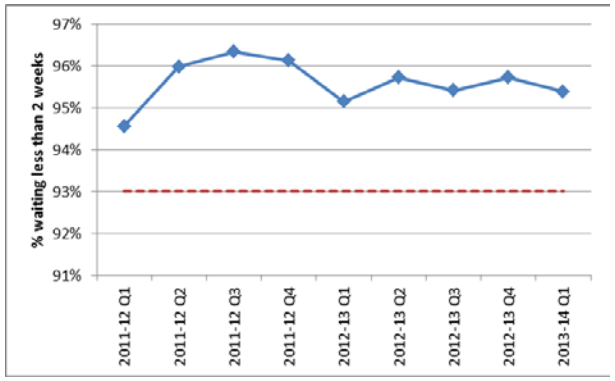
RAG based on comparison to Operational Standard of 95%



Priority 9 - NHS Constitution rights and pledges

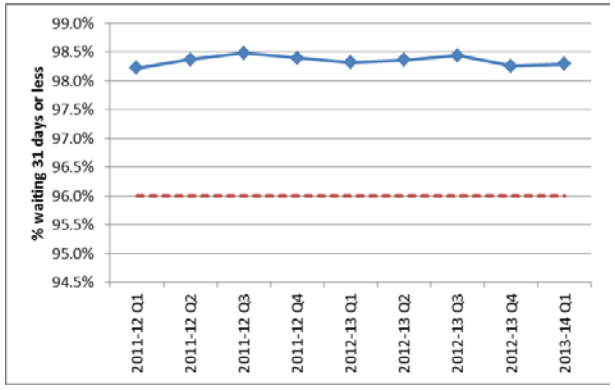
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)

		% waiting less than 2 weeks	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	95.4%			Green
Change on previous year	2012-13 Q1	0.2%	0.25%	↑	
Long term change	2011-12 Q1	0.8%	0.88%	↑	



Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers

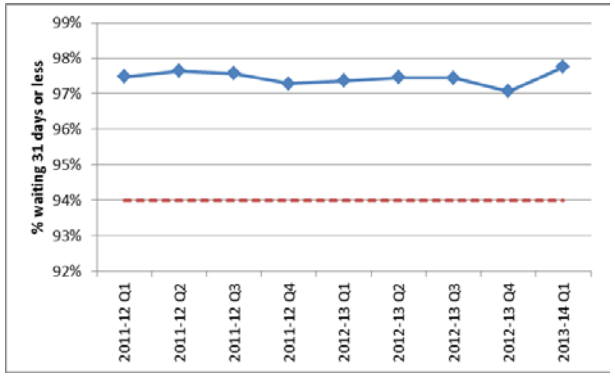
		% waiting 31 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	98.3%			Green
Change on previous year	2012-13 Q1	0.0%	-0.03%	↓	
Long term change	2011-12 Q1	0.1%	0.07%	↑	



Priority 9 - NHS Constitution rights and pledges

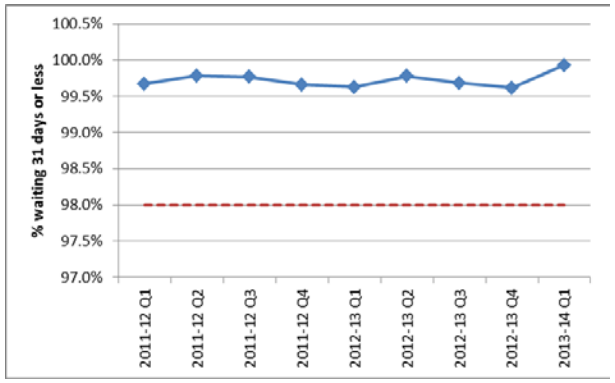
Maximum 31-day wait for subsequent treatment where that treatment is surgery

		% waiting 31 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	97.8%			Green
Change on previous year	2012-13 Q1	0.4%	0.39%	↑	
Long term change	2011-12 Q1	0.3%	0.28%	↑	



Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen

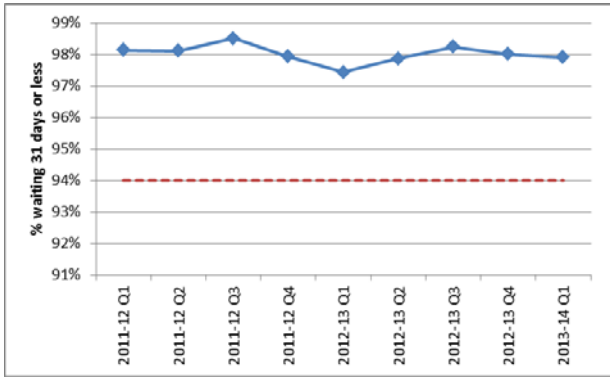
		% waiting 31 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	99.9%			Green
Change on previous year	2012-13 Q1	0.3%	0.30%	↑	
Long term change	2011-12 Q1	0.3%	0.25%	↑	



Priority 9 - NHS Constitution rights and pledges

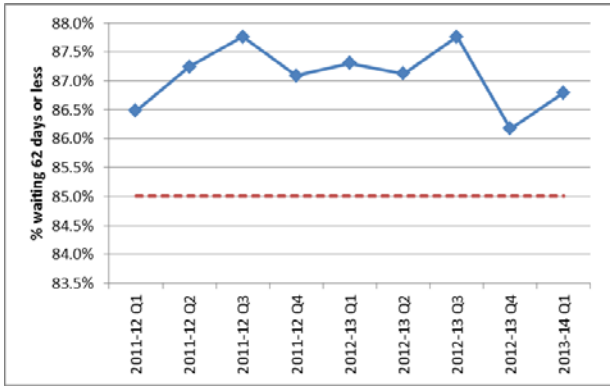
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy

		% waiting 31 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	97.9%			Green
Change on previous year	2012-13 Q1	0.5%	0.49%	↑	
Long term change	2011-12 Q1	-0.2%	-0.23%	↓	



Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer

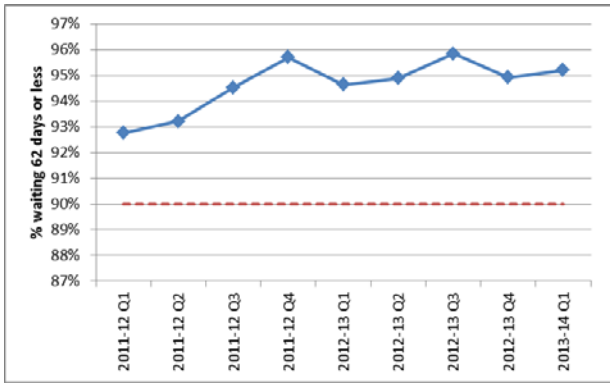
		% waiting 62 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	86.8%			Green
Change on previous year	2012-13 Q1	-0.5%	-0.59%	↓	
Long term change	2011-12 Q1	0.3%	0.36%	↑	



Priority 9 - NHS Constitution rights and pledges

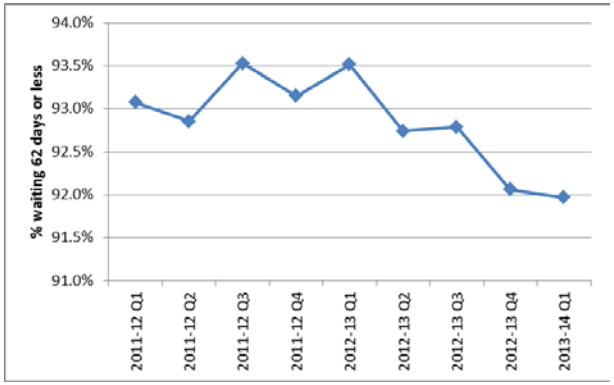
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers

		% waiting 62 days or less	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	95.2%			Green
Change on previous year	2012-13 Q1	0.6%	0.60%	↑	
Long term change	2011-12 Q1	2.4%	2.64%	↑	



Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)

		% waiting 62 days or less	% Change	Direction
Current Value	2013-14 Q1	92.0%		
Change on previous year	2012-13 Q1	-1.5%	-1.65%	↓
Long term change	2011-12 Q1	-1.1%	-1.19%	↓

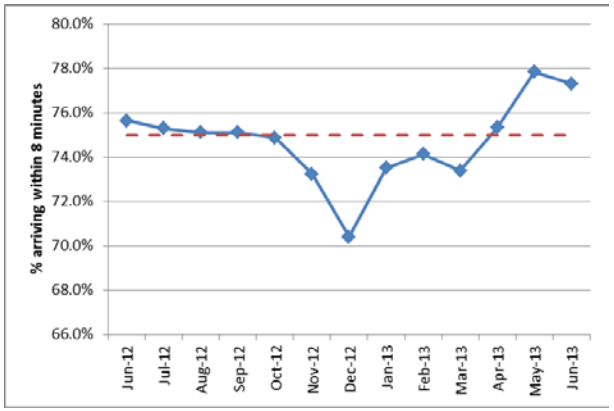


Priority 9 - NHS Constitution rights and pledges

Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)

		% arriving within 8 minutes	% Change	Direction	RAG Colour
Current Value	Jun-13	77.3%			Green
Change on previous year	Jun-12	1.7%	2.21%	↑	
Long term change	Jun-12	1.7%	2.21%	↑	

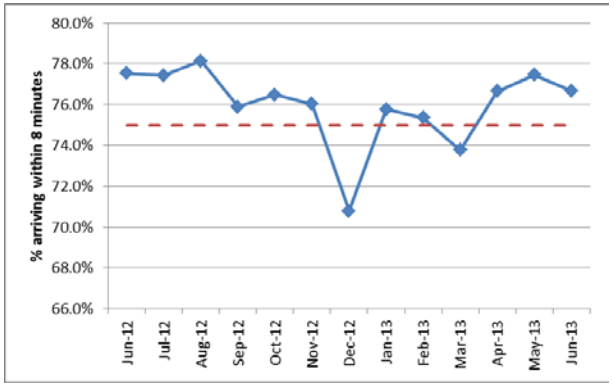
RAG based on comparison to Operational Standard of 75%.



Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)

		% arriving within 8 minutes	% Change	Direction	RAG Colour
Current Value	Jun-13	76.7%			Green
Change on previous year	Jun-12	-0.8%	-1.09%	↓	
Long term change	Jun-12	-0.8%	-1.09%	↓	

RAG based on comparison to Operational Standard of 75%.

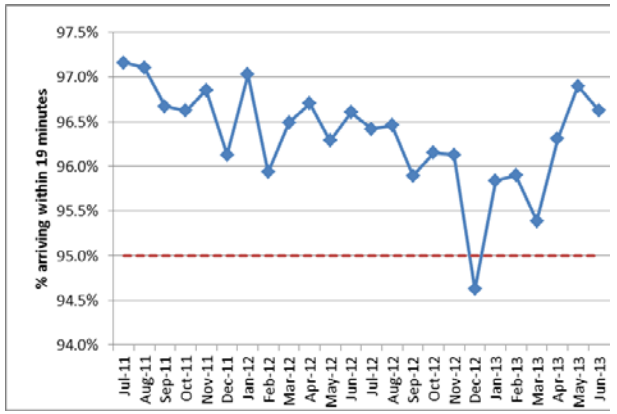


Priority 9 - NHS Constitution rights and pledges

Category A calls resulting in an ambulance arriving at the scene within 19 minutes

		% arriving within 19 minutes	% Change	Direction	RAG Colour
Current Value	Jun-13	96.6%			Green
Change on previous year	Jun-12	0.0%	0.03%	↑	
Long term change	Apr-11	-0.7%	-0.68%	↓	

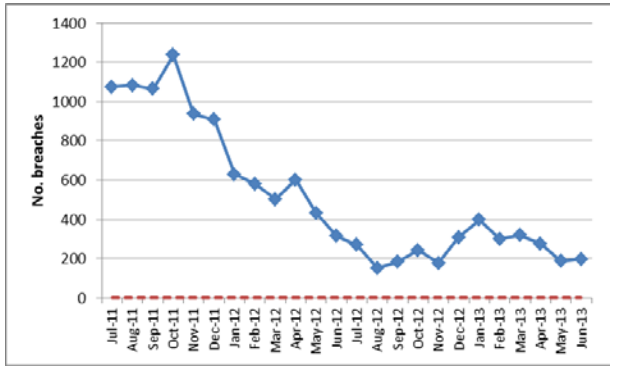
RAG based on comparison to Operational Standard of 95%



Mixed Sex Accommodation Breaches

		No. breaches	% Change	Direction	RAG Colour
Current Value	Jun-13	198			Red
Change on previous year	Jun-12	-116	-36.94%	↓	
Long term change	Dec-10	-11604	-98.32%	↓	

RAG based on comparison to Operational Standard of 0

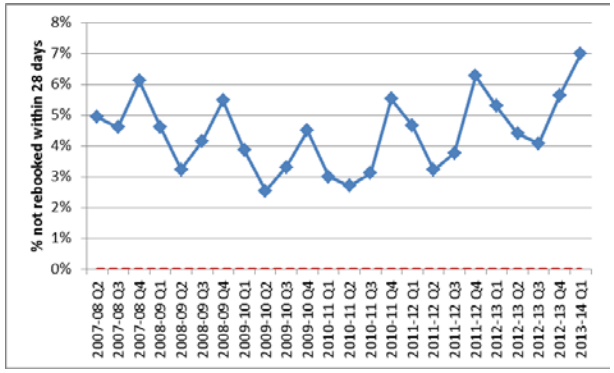


Priority 9 - NHS Constitution rights and pledges

All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

		% not rebooked within 28 days	% Change	Direction	RAG Colour
Current Value	2013-14 Q1	7.0%			Red
Change on previous year	2012-13 Q1	1.7%	32.18%	↑	
Long term change	1994-95 Q1	-6.7%	-48.92%	↓	

RAG based on comparison to Operational Standard of 0%



Priority 10 - Becoming and excellent organisation

NHS England Staff Barometer

Barometer Theme	% Positive Responses
Staff Motivation	64.1%
Job Design	57.5%
Staff Engagement	65.0%
Staff Satisfaction	62.9%
View of NHS England	59.5%

Priority 11 - High quality financial management – Month 4 Data

	Surplus	Planned £m	Actual/FOT £m	Variance £m	RAG	Change on previous month
1	Clinical Commissioning Groups - year to date	212.9	207.6	(5.3)	Green	Not previously reported
2	Clinical Commissioning Groups - full year forecast outturn	615.0	598.3	(16.7)	Green	Not previously reported
3	Direct Commissioning - year to date	73.7	51.0	(22.7)	Amber	Not previously reported
4	Direct Commissioning - full year forecast outturn	214.7	151.2	(63.5)	Amber	Not previously reported
5	NHS England (total) - full year forecast outturn	533.7	453.5	(80.2)	Green	Not previously reported

	QIPP (excluding implied provider efficiencies)	Planned £m	FOT £m	Variance £m	RAG	Change on previous month
6	Clinical Commissioning Groups - full year forecast outturn delivery	1,633.0	1,539.7	(93.3)	Amber	Not previously reported
7	Direct Commissioning - full year forecast outturn delivery	379.9	329.0	(50.9)	Amber	Not previously reported

	Costs management*	Within budget	Within budget	Variance £m	RAG	Change on previous month
8	Central - management costs	Y	Y	0.0	Green	None
9	Central - programme costs	Y	Y	n/a	Green	None
10	Clinical Commissioning Groups - management costs	Y	Y	n/a	Green	Not previously reported

*Full year forecast outturn

	Deficit reporting	Planned number	Forecast number	Variance		
11	Number of CCGs forecasting a deficit position	9	9	0	Green	Not previously reported

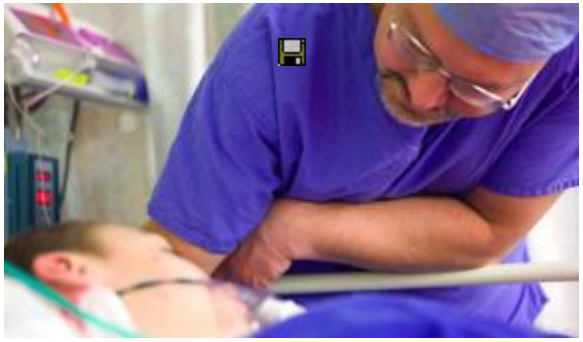
Business Plan Deliverable Status Report: 10 June 2013 - 02 Aug 2013

Deliverable Lead	Deliverable Ref.	Deliverable description	Baseline Deliverable Date	Latest Forecast date/ Actual date	Business Plan Deliverables: Status	
					Current Deliverable Status	Rationale for deliverable RAG rating including actions to address the Red or Amber-Red Status and key activities this period:
Deliverables with baseline date in this reporting period and deliverables with baseline date in the past						
National Medical Director / Chief Nursing Officer	1.1	• Clinical leadership will underpin all of our work to ensure sufficient focus on outcomes. We will produce vision statements for each Outcomes Framework domain by May 2013 setting out the high level approach the commissioning system will take to improve outcomes and reduce health inequalities	May-13		AG	There has been a decision by the Executive Team that domain visions should not be published as standalone documents, but that they should be used as a resource for NHS England, Commissioners and Clinicians in taking forward their responsibilities, to ensure they have the greatest impact on outcomes.
Chief Operating Officer	1.2	• We will produce and embed single operating models for all directly commissioned services by June 2013. These will deliver improved outcomes by driving up standards in mental and physical health service provision and address unwarranted variation in current practice. At least 80% of direct commissioning intentions delivered to time by April 2014.	Jun-13	Jul-13	AR	While single operating models published, embedding is not yet fully completed. Directly Commissioned Services Committee will oversee the implementation of the direct commissioning strategic priorities as agreed by NHS England Board. The Committee will deliver leadership and direction to the implementation of the single operating models for directly commissioned services. In addition the embedding of single operating models is included within Area Team plans for 2013/14.
National Medical Director	2.2	• Our clinical vision for domain one (published in May 2013) will set out the approach the commissioning system will take to improve outcomes and tackle inequalities in relation to mortality. This will focus particularly on prevention and earlier diagnosis of illness.	May-13		AG	See rationale against key deliverable 1.1.
Chief Nursing Officer	8.2	• As part of our nursing strategy Compassion in practice we will publish a range of tools and resources aimed at supporting the nursing contribution to the dementia challenge. These resources will be published between April and July 2013.	Jul-13	Jul-13	Complete	As part of the delivery of the nursing strategy Compassion in Practice, a range of tools and resources have been published through the 6C's hub to support the nursing contribution to the dementia challenge
National Medical Director	8.3	• Our clinical vision for domain two of the outcomes framework will be published in May 2013. This will include how the commissioning system can work to deliver improved outcomes for dementia.	May-13		AG	See rationale against key deliverable 1.1.
National Medical Director	16.1	• Our vision statement for Domain 2 will be published May 2013 will include how the system we will deliver improved outcomes and reduced inequalities for children and young adults with special education needs or disabilities.	May-13		AG	See rationale against key deliverable 1.1.
National Director: Policy / Chief Finance Officer (Reporting by Policy)	20.1	• A Choice and Competition framework and supporting documents will be published by July 2013. This will set out guidance for how CCGs can use choice and competition as levers to improve standards of care. This include guidance in relation to the use of Any Qualified Provider contracts.	Jul-13		AR	Monitor is reconsidering the content in the Choice and Competition Framework and the publication of documents is being reviewed though this is unlikely to be before late Autumn 2013.

Business Plan Deliverable Status Report: 10 June 2013 - 02 Aug 2013

Deliverable Lead	Deliverable Ref.	Deliverable description	Baseline Deliverable Date	Latest Forecast date/ Actual date	Business Plan Deliverables: Status	
					Current Deliverable Status	Rationale for deliverable RAG rating including actions to address the Red or Amber-Red Status and key activities this period:
Deliverables completed prior to this reporting period						
National Director: Policy	7.2	· We will publish a common purpose framework for integrated care with national partners by May 2013.	May-13	May-13	**Complete**	Integrated Care and Support: Our Shared Commitment published on 14 May 2013, endorsed by 13 national partner organisations, setting national and local commitments to enable and encourage better person-centred coordinated care and support becoming 'the norm' over the coming years
National Medical Director	15.3	• We will for the first time have a National Clinical Director for Maternity and Women's Health to lead on clinical service improvement, reducing variation and generating information for the public on maternity services.		May-13	**Complete**	National Clinical Director for Maternity & Women's Health has been appointed
National Medical Director	18.2	• Quality surveillance groups (QSG) will be operational in every region from April 2013. They will bring together local commissioners regulators and other bodies to provide multi agency surveillance and response to quality and safety issues in all areas of healthcare.	Apr-13	Apr-13	**Complete**	Quality surveillance groups (QSG) are operational in every region since April 2013 and the action is complete and closed.
Chief Operating Officer	19.1	• 'Everyone counts' set out the framework by which we expect local health systems to plan. Our aim is to provide the freedom and support for CCGs to develop their own priorities through their input into the joint Health and Wellbeing Strategy.		Dec-13	**Complete**	Everyone Counts was published December 2012.
Chief Operating Officer	19.2	• We have asked each CCG to identify local priorities against which it will make progress during the year - these will form part of our assurance of each CCG and will be taken into account when determining if the CCG should be rewarded through the Quality Premium.		Apr-13	**Complete**	Each CCG identified its local priorities by 31/03/13
Chief Operating Officer	22.3	• We are facilitating joined up planning locally. 'Everyone counts' set out the requirements on CCGs and area teams to work with local partners to develop Joint Health and Wellbeing Strategy		Apr-13	**Complete**	Joint Health and Wellbeing Strategies are being overseen by Local Authorities. Joint Health and Wellbeing Strategies have been developed.

Section C: NHS Performance and Finance



NHS England Performance Report September 2013

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

This section presents latest information on a number of important areas of performance and other developments in the NHS. This supplements the information presented in other sections by giving a focus on the most current indicators and by also moving beyond the indicators in the 11-Point Scorecard. As this section will be based on the latest issues arising in the NHS, its content can vary from quarter to quarter in the light of actual performance.

For the September 2013 Board Report it contains:

- Urgent Care
  - A&E performance
  - Ambulance performance
  - Progress with NHS 111
- 18 weeks referral to treatment waiting times
- Cancer Waits
- Activity, including the number of GP referrals to hospital and the number of hospital admissions
- The Friends and Family Test
- Financial Performance

A&E Performance

The NHS achieved the 95% A&E standard on average for Q1 2013/14 and has been achieving the standard on a weekly basis since week ending 28 April after a period in February to April, when it was not achieved. As at week ending 18 August, the quarter to date performance is 96.6% of patients were seen in under 4 hours in all types of A&E. Figure 1 shows weekly performance against the standard.

In an average week, there are approximately 450,000 A&E attendances, approximately 300,000 to major A&E departments (type 1), 150,000 to Minor Injuries Units/Walk-in Centres (type 3) and 10,000 to specialist A&Es such as eye hospitals (type 2). Of these attendances, approximately 15,000 patients wait longer than 4 hours, mainly at type 1 A&Es, with only approximately 300 at Type 3 A&Es and less than 100 at type 2 A&Es. There are approximately 73,000 emergency admissions through A&E departments each week, 72,000 at type 1 A&Es, and the remaining 1000 through Type 2 and type 3 A&E departments. At type 1 A&E departments approximately 25% of attendances result in a hospital admission, with a further 28,000 hospital emergency admissions through non-A&E routes, such as direct admissions by GPs.

Figure 1

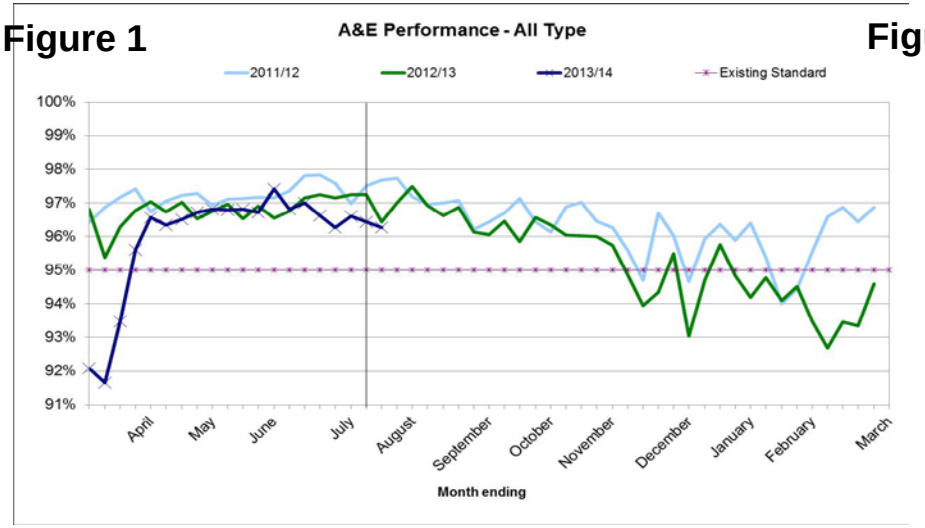
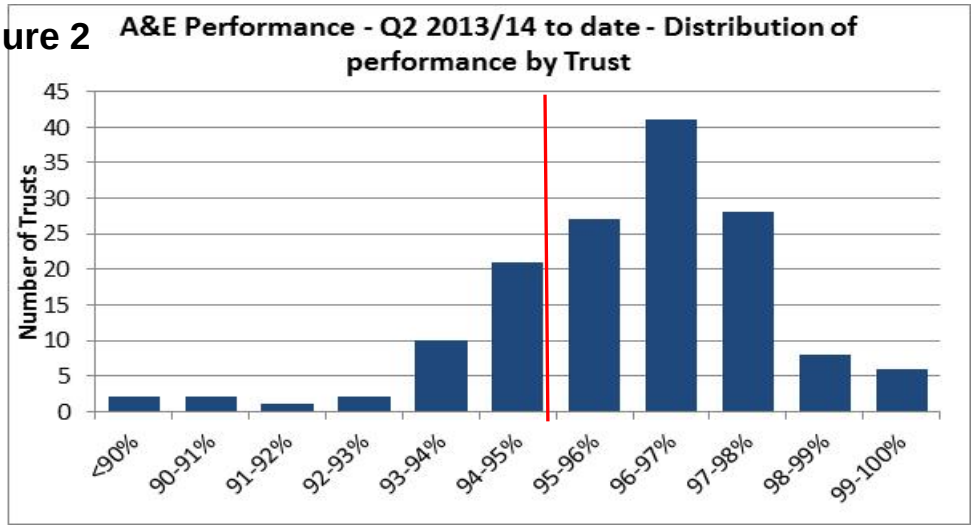


Figure 2



Within the overall aggregate national position, performance by provider varies. Q2 performance to date varies by acute provider from 83.8% to 99.7%, with the distribution by trust as shown in Figure 2. 38 trusts have quarter to date performance below the 95% standard, including 3 trusts below 90%. CCGs should be discussing performance against the standard with their local providers and working with them to ensure performance recovers.

Ambulance Performance

The June data shows England performance, in aggregate, achieving all three standards as it did in the previous two months. Since June 2012, response times for the Category A 8 mins standard are reported separately for Category A8 Red 1 (immediate time critical calls) calls and Category A8 Red 2 (serious but less immediately time critical calls) calls. Since this change, the NHS has struggled to stay above 75% for Cat A Red 1 calls. Nationally, performance has been below standard since October 2012, with recovery achieved in April 2013 and continued in May and June where performance was 77.3% for Category A8 Red 1, and 76.7% for CAT A8 Red 2. The national position on the Cat A 19 mins Transportation Standard was 96.6%.

In June 2013, there were 10,226 Red 1 calls resulting in an emergency response (down from 10,891 in May), 211,958 Red 2 calls resulting in an emergency response (down from 221,995 in May), and 232,356 Category A19 calls resulting in an ambulance arriving at the scene of the incident.

Although the standards are being achieved in aggregate across the country, anecdotally there are reports of handover delays from ambulance crews to A&E staff. Sustaining and improving delivery on these standards will be also be covered by the development of local system recovery and improvement plans.

Against the ambulance standards 2013/14 performance to date varies by Ambulance Trust from 71.1 to 82.1% for Cat A Red 1, from 73.4 to 79.7% for Cat A Red 2, and from 93.8% to 98.2% for Cat A 19, as shown n in Figures 1, 2 & 3 respectively. Against each standard there are 2 trusts below the standard, with EMAS and EoE AS both missing two. CCGs should be working with these ambulance trusts to ensure performance recovers.

Figure 1

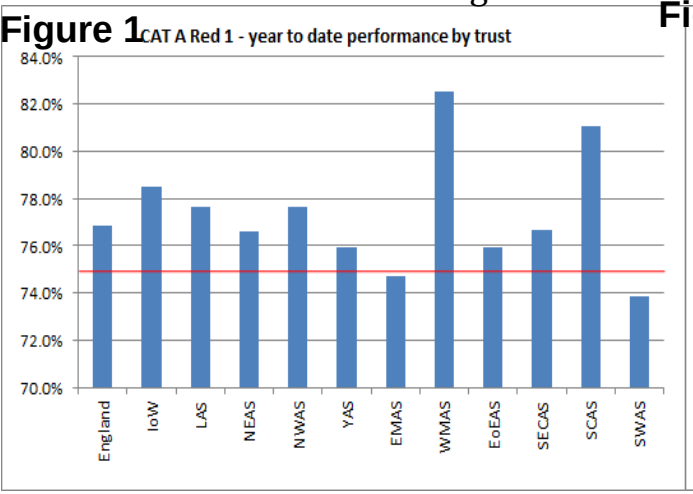


Figure 2

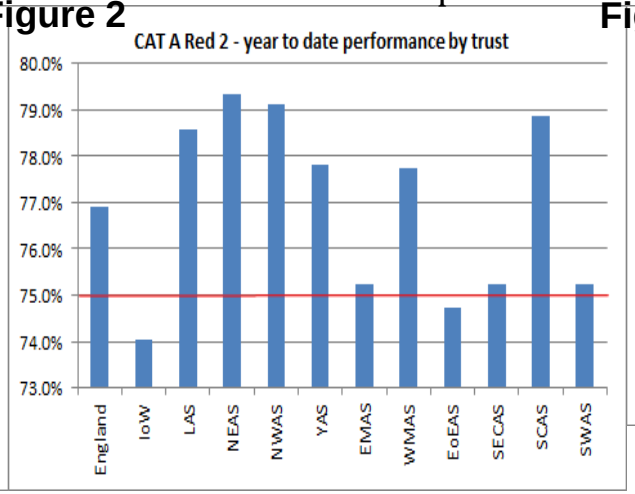
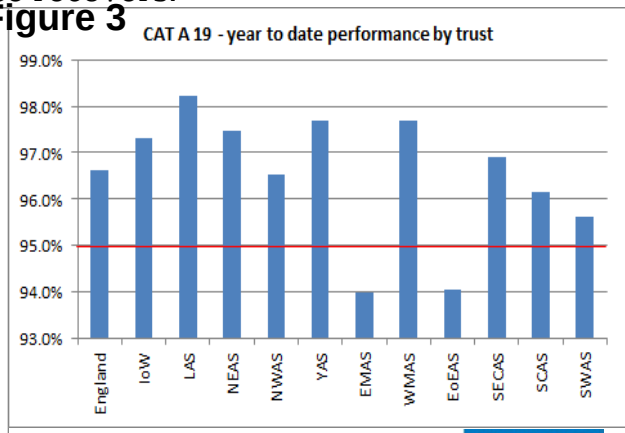
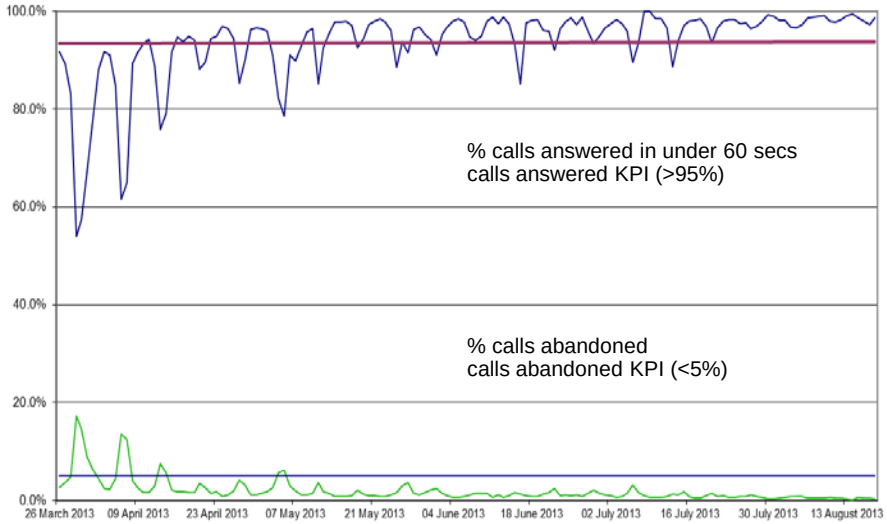


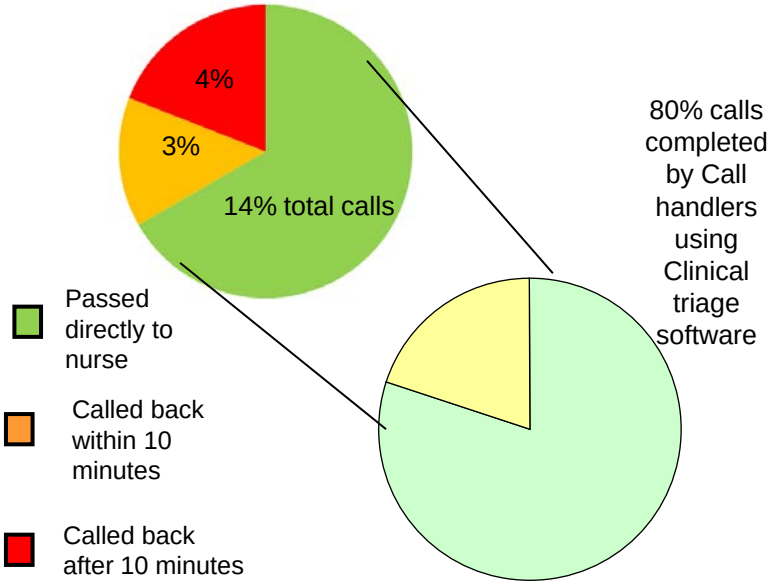
Figure 3



September 2013 NHS 111 performance

NHS 111 coverage has improved from 20% (end of Feb) to over 90%. Some of the new sights failed to perform as expected but performance is now good with key targets largely being delivered. The calls abandoned KPI (under 5%) is now being met across the country (national average 0.4%), although some sites are still unable to meet the calls answered within 60 seconds KPI (over 95%) at peak times (national average 98.3%). Recently published data from June, demonstrates the low level of calls that require further assessment by a clinician (22%), and only 7% of calls require a call back. Just under half of these call backs happen within 10 minutes.





- NHSD recently announced it would be gradually withdrawing from all of its contracts in a planned and managed way. Work is now underway to ensure its NHS 111 contracts are safely transferred to alternative providers such as ambulance trusts.
- NHS England has developed and implemented a national Checkpoint approval system, before sites are launched, to robustly test quality and capacity;
- In response to concerns raised by GPs about the length of messages received from NHS 111, NHS England has developed a streamlined post-event messaging system, which gives GPs only the most relevant facts about a patient's interaction with NHS 111.
- NHS England will ensure there is enough time to learn lessons from its Urgent & Emergency Care Review, and the NHS 111 clinical quality and safety review. Futures work streams, before supporting further procurements for NHS 111 services;

18 weeks Referral To Treatment (RTT) times (1)

June data continues to show that elective waiting times are broadly stable and the NHS performance standards are being met. Where treatment required a hospital admission (admitted patients): 91.7% started treatment within 18 weeks, compared to 92.0% in June 2012, as shown in Figure 1. Where treatment did not require a hospital admission (non-admitted patients): 97.4% started treatment within 18 weeks, compared to 97.8% in June 2012, also shown in Figure 1. By the end of June 2013 the waiting list size had grown to 2.88 million people, of which 94.6% had waited less than a year, and compared to 2.64 million in June 12. Of the 2.88 million, 46,355 have been waiting for more than 26 weeks, 1.6% of the total, and 318 had been waiting more than a year (0.011% of the total). Further analysis has confirmed that the increase in the numbers waiting does not present an immediate risk to delivery of the standards going forward, although the position will be kept under review.

Each month approximately 300,000 patients are treated on an admitted pathway and about 850,000 on a non-admitted pathway. In June 2013, 91.7% of the admitted patients waited less than 18 weeks, a further 5.0% waited between 18 and 26 weeks. Only 200 waited more than a year (0.07% of the total treated). Some of these patients will have chosen to wait longer than 18 weeks to be treated at a time most convenient for them. For non-admitted patients, 97.4% were treated in 18 weeks, with a further 1.8% treated between 18 and 26 weeks. 248 were treated after waiting more than a year (0.03% of the total treated).

Figure 1 Percentage of pathways completed within 18 weeks

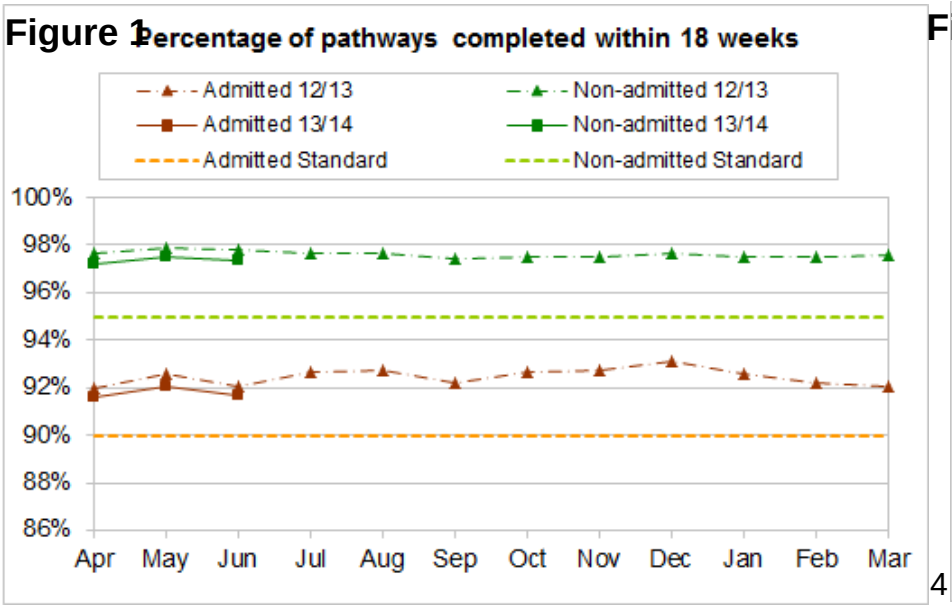
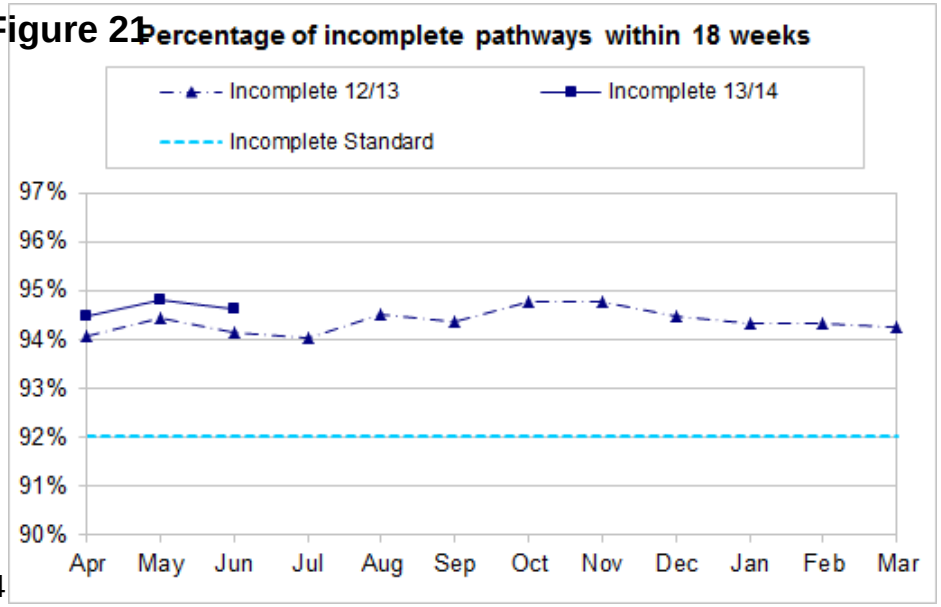


Figure 2 Percentage of incomplete pathways within 18 weeks



18 weeks Referral To Treatment (RTT) times (2)

June 2013: Trusts with 10 or more 52 plus week waiters	
Barts Health NHS Trust	51
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT	40
King's College Hospital NHS FT	31
Kingston Hospital NHS Trust	24
The Whittington Hospital NHS Trust	23
East Kent Hospitals University NHS FT	21
Doncaster & Bassetlaw Hospitals NHS FT	18
The Royal Orthopaedic Hospital NHS FT	13

At the end of June 2013, there were 318 patients waiting over 52 weeks on an incomplete pathway, compared to 437 at the end of May. This compares to a total of 3,478 patients waiting at the end of June 2012.

Within the overall aggregate national position, performance by provider varies. June performance on admitted pathways varies by provider from 65.4% to 100%, with 12 providers with performance below 85% and 15 providers with performance between 85% and the standard of 90% and the distribution as shown in Figure 1. On incomplete pathways, one trust has performance below 87% and 11 trusts have performance between 87% and the standard of 92%, as shown in Figure 2. Area Teams will be discussing this performance with CCGs as part of assurance and working with them to ensure performance recovers. The position is not new and we routinely see numbers of providers and commissioners not achieving these standards each month as illustrated by the chart overleaf.

Figure 1

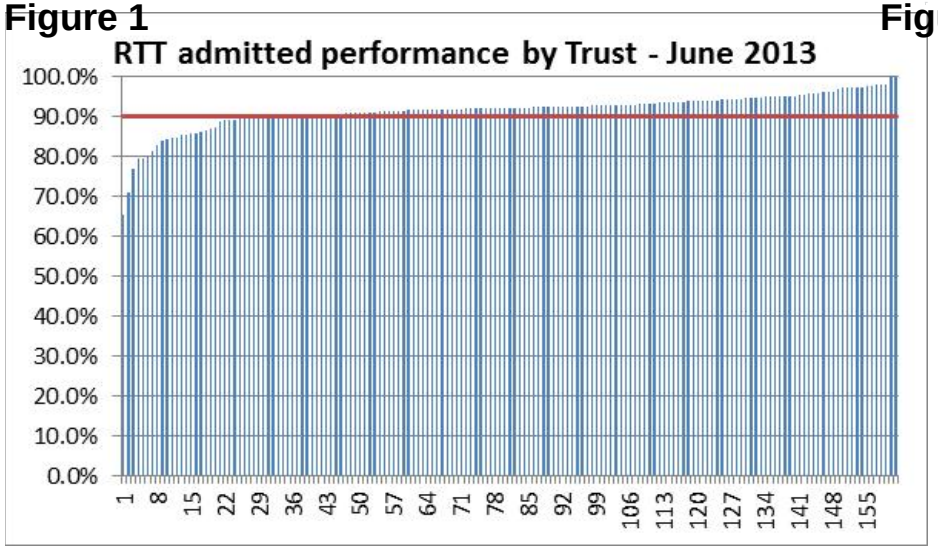
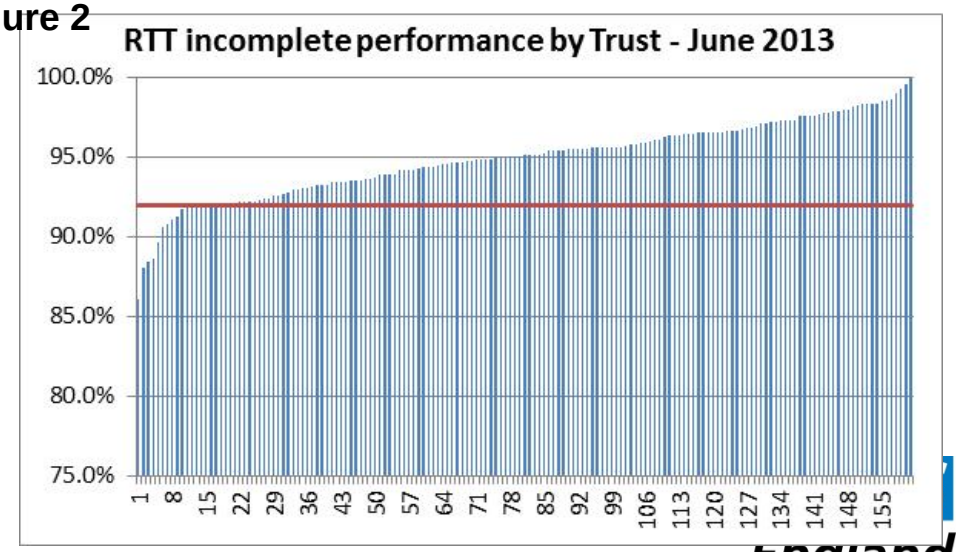
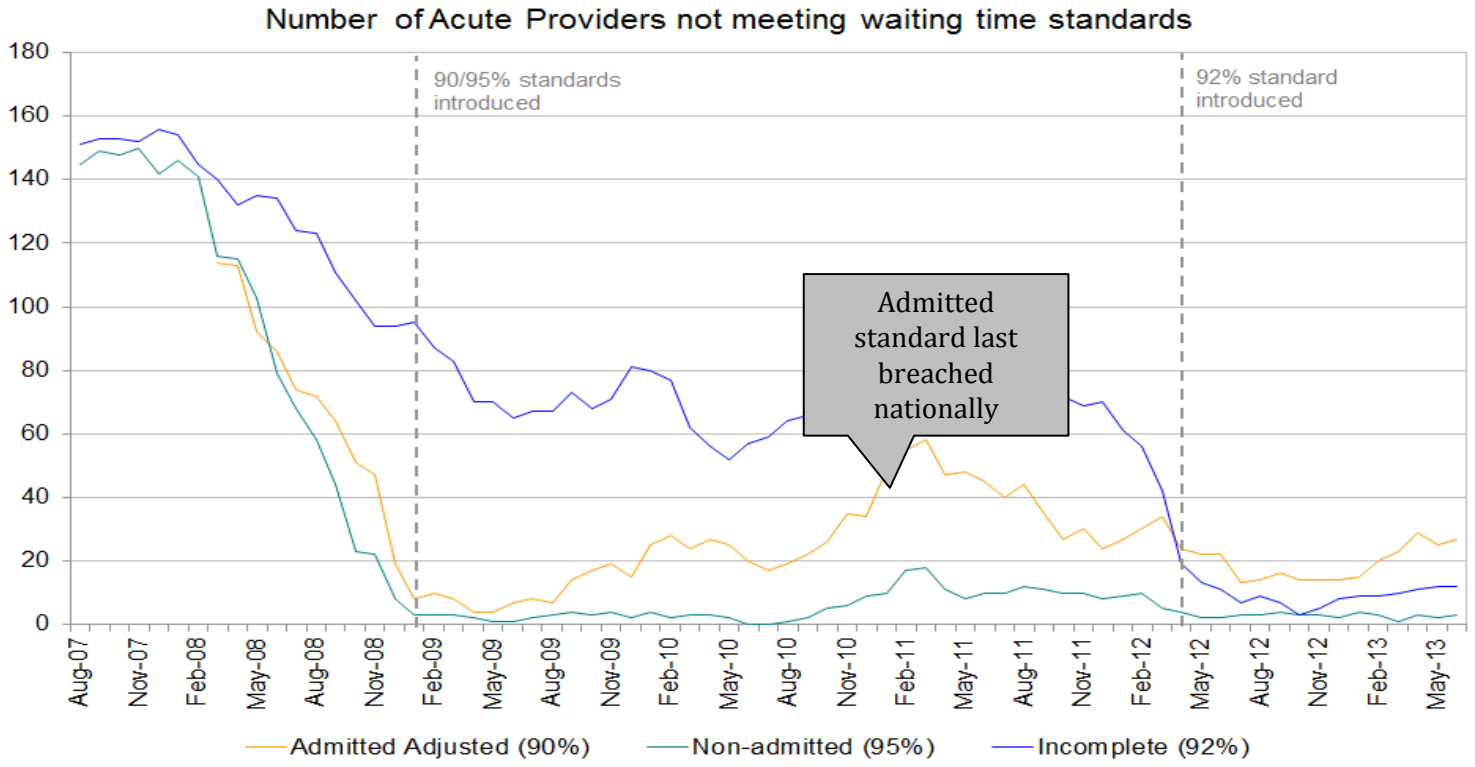


Figure 2



18 weeks Referral To Treatment (RTT) times(3)

The chart below summarises performance against the standards by providers over time and shows that the numbers have been broadly stable since the 92% standard for incomplete pathways was introduced in April 2012.



The numbers of Providers failing the Standards each month are as follows :

	May-10	Jun-12	May-13	Jun-13
Admitted (90% standard)	25	22	25	27
Non-admitted (95% standard)	2	2	2	3
Incomplete (92% standard)	52	11	12	12

Diagnostic Waits

June data shows that at the end of June 2013, the percentage of people waiting 6 weeks or more for a diagnostic test was 0.9%, down from 1% in May 2013, as shown in Figure 1. In June, 688,722 patients had a diagnostic test, and 682,482 (99.1% of those referred for a test) had their test within 6 weeks of referral. Performance varies by CCG, from no patients waiting more than 6 weeks for a diagnostic test to 28.6% waiting over 6 weeks. The performance in 47 CCGs was worse than the standard, as shown in Figure 2 below. Area Teams will be discussing this performance with CCGs as part of assurance and working with them to ensure performance recovers.

Figure 1

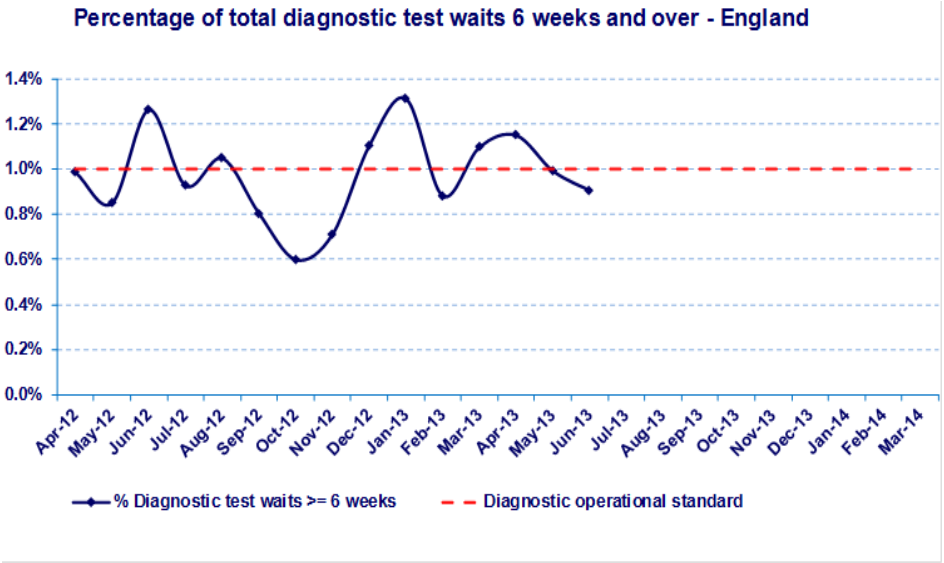
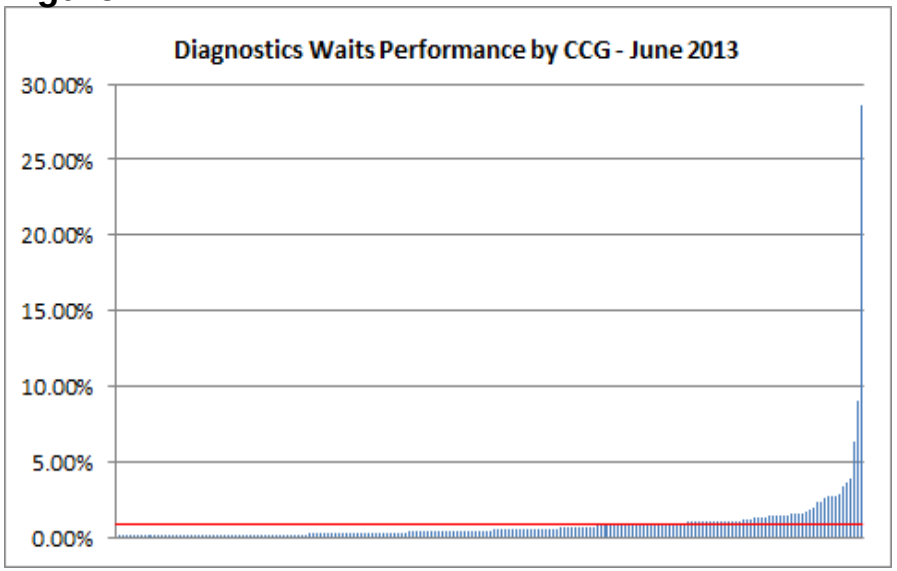


Figure 2



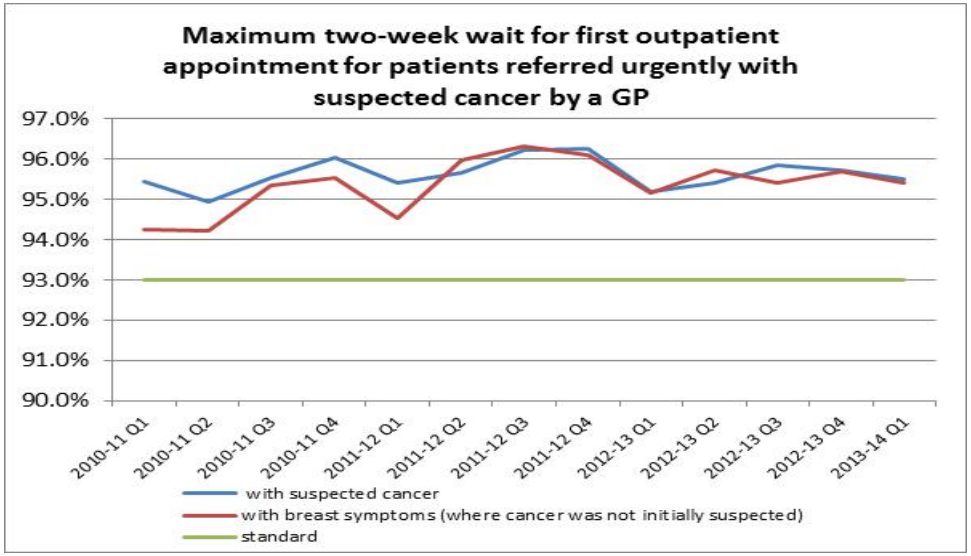
Cancer Waits (1)

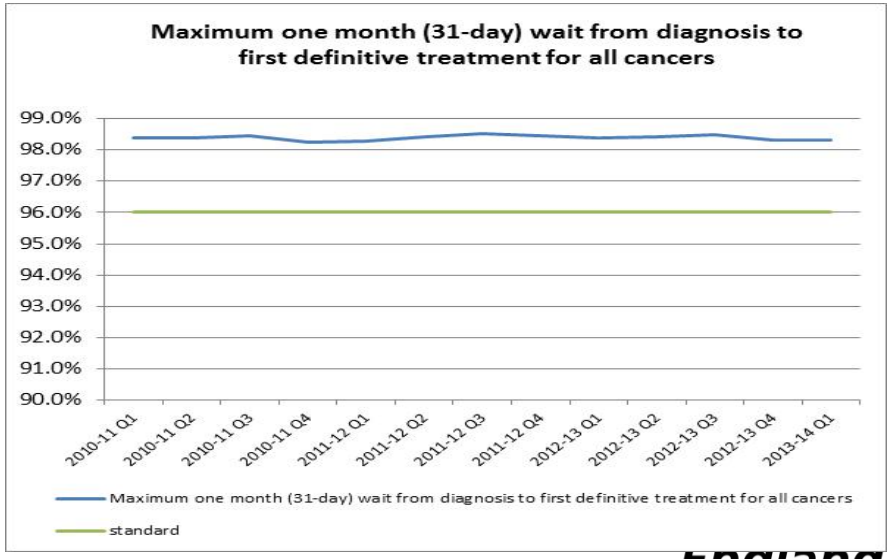
Latest data shows that the NHS continues to meet all cancer waiting time operational standards at the national level.

All cancer two week wait : The standard is 93% and in Q1 95.5% of patients were seen within 2 weeks. Approximately 300,000 patients are seen each quarter by specialists after an urgent GP referral for suspected cancer. The proportion of patients seen within 14 days varies by CCG. The performance standard was met for the residents of all but nine CCGs, of which only one saw less than 90% of patients within 14 days.

Two week wait for symptomatic breast patients : The standard is 93% and in Q1 95.4% of patients were seen within 2 weeks. Approximately, 50,000 patients who exhibit breast symptoms, where cancer was not initially suspected, are seen each quarter after being urgently referred. In Q1, performance for the residents of 33 CCGs did not meet the standard, with 9 reporting performance below 90%.

One Month (31-day) diagnosis to first treatment wait : The standard is 96% and in Q1 98.3% of patients were seen within one month. Approximately, 60,000 patients each quarter begin a first definitive treatment for cancer. In Q1, performance for the residents of 9 CCGs did not meet the standard, although performance was above 90%.



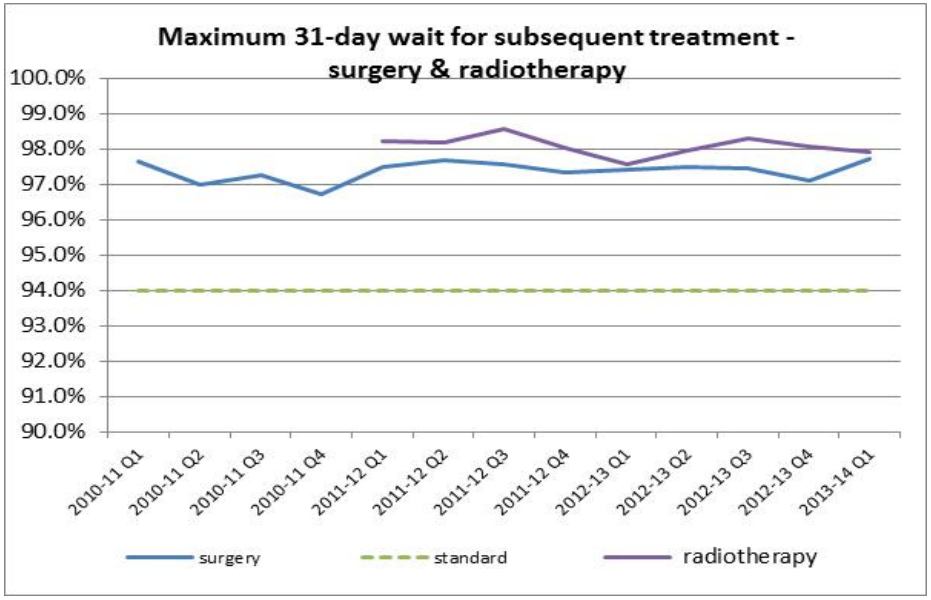


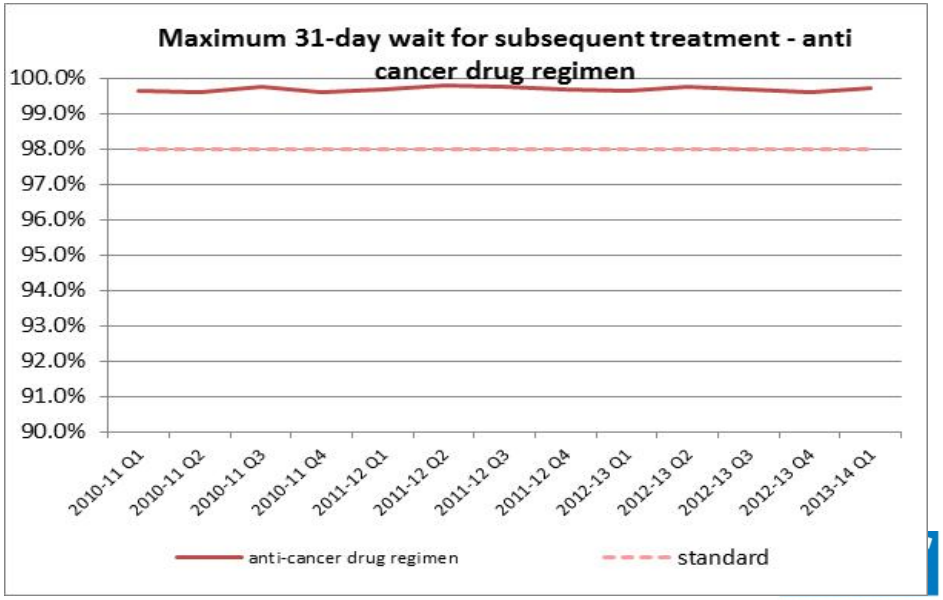
Cancer Waits (2)

One Month (31-day) wait for second or subsequent treatment - surgery : The standard is 94% and in Q1 97.7% of patients were seen within one month. Performance over the last few quarters is shown in the chart below. Approximately, 8,000 patients each quarter begin a second or subsequent treatment of surgery for cancer. In Q1, performance for the residents of 7 CCGs did not meet the standard, and in 2 their performance was below 90%.

One Month (31-day) wait for second or subsequent treatment – anti cancer drug regimen : The standard is 98% and in Q1 99.7% of patients were seen within one month. Performance over the last few quarters is shown in the chart below. Approximately, 16,000 patients each quarter begin a second or subsequent treatment of an anti cancer drug regime. In Q1, performance for the residents of all CCGs meet the standard.

One Month (31-day) wait for second or subsequent treatment - radiotherapy : The standard is 94% and in Q1 97.9% of patients were seen within one month. Performance over the last few quarters is shown in the chart below. Approximately, 22,000 patients each quarter begin a second or subsequent treatment of radiotherapy. In Q1, performance for the residents of 9 CCGs did not meet the standard, and in 3 performance was below 90%.





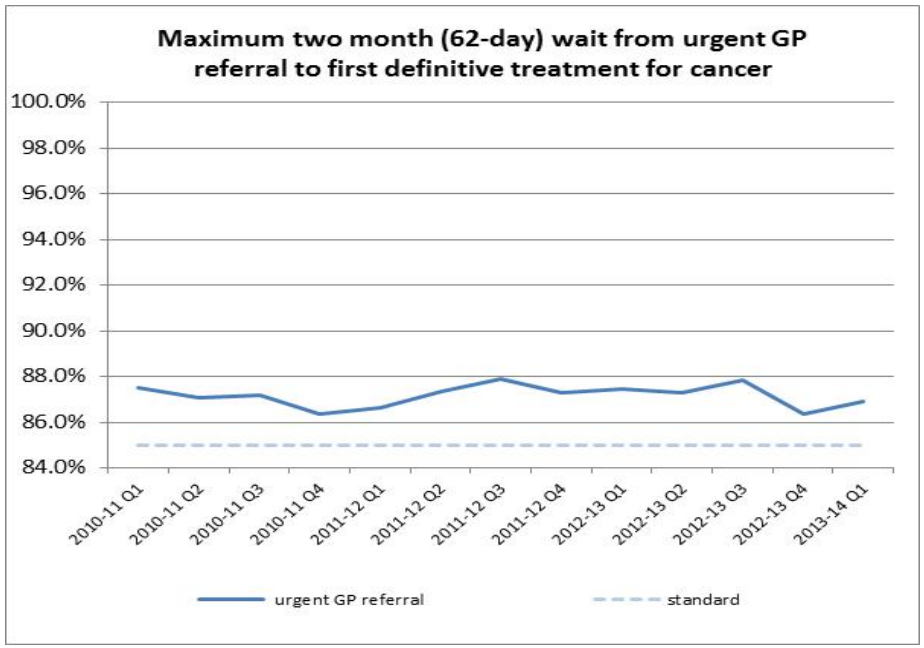
England

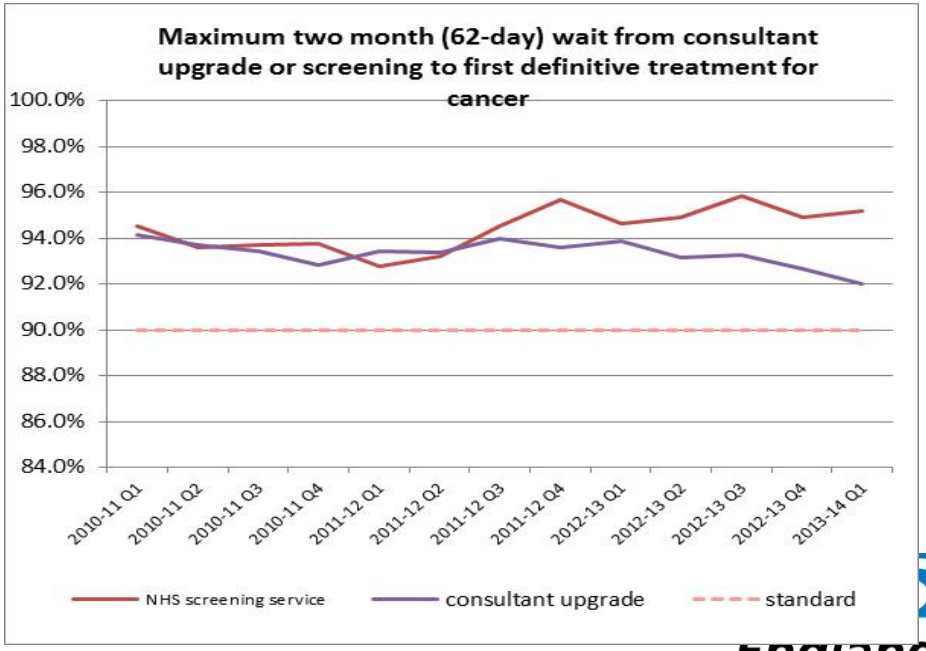
Cancer Waits (3)

Two Month (62-day) urgent GP referral first treatment wait : The standard is 85% and in Q1 86.9% of patients were treated within 2 months. Performance is shown in the figure below. Approximately, 30,000 patients begin first definitive treatment for cancer following an urgent GP referral each quarter. In Q1, 60 CCGs did not meet the standard, with 15 reporting performance below 80%.

Two Month (62-day) wait from consultant upgrade to first treatment : There is no standard for this waiting time as the numbers are small, and in Q1 92.0% of patients were treated within 2 months. Approximately, 4,000 patients begin first definitive treatment for cancer following an urgent GP referral each quarter. In Q1, performance for the residents of 28 CCGs was below 90%.

Two Month (62-day) wait from referral from screening to first treatment : The standard is 90% and in Q1 95.2% of patients were treated within 2 months. Approximately, 4,600 patients begin first definitive treatment for cancer following a referral from screening each quarter. In Q1, performance for the residents of 9 CCGs did not meet the standard, with 2 reporting performance below 85%.

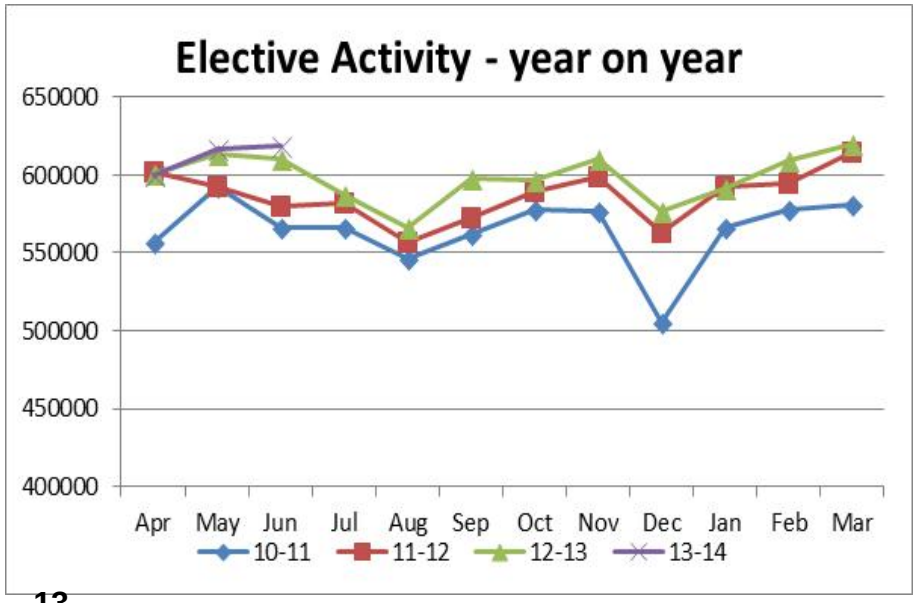


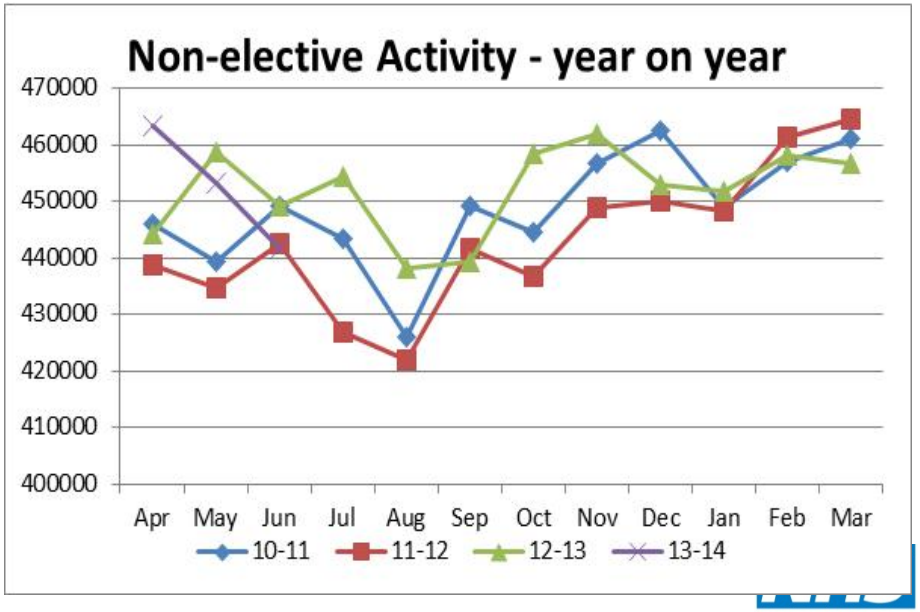


Activity

Not withstanding the data problems with activity, the most recent monthly return indicates that both elective and non-elective activity is 0.5% higher in the first three months of 2013/14 as compared to the same period in 2012/13.

	April to June 2012	April to June 2013	% change
GP referrals made (G&A)	2,790,800	2,959,529	2.6%
Other referrals made (G&A)	1,666,369	1,728,208	0.4%
GP referrals seen (G&A)	2,248,547	2,408,906	3.7%
1st outpatient appointments seen (G&A)	3,943,125	4,084,327	0.2%
Day case rate	79.6%	80.4%	-
All G&A ordinary admissions and day case admissions (elective growth)	1,825,346	1,896,332	0.5%
Non-elective admissions (G&A)	1,367,418	1,373,595	0.5%
A&E Attendances	5,587,707	5,554,230	-0.6%





Friends and Family Test

Friends & Family Test: Background : The test is initially for all acute providers of adult NHS funded care covering services for inpatients and patients discharged from A&E (type 1 and 2). From 1st April 2013, data collection and reporting became mandatory for acute providers.

Benefits of the Friends and Family Test : The Friends and Family Test is a simple, comparable test which, when combined with follow-up questions, provides a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations. It will mean that staff from "boards to wards" have access to up-to-date patient feedback and thus will be informed and empowered to take immediate action to tackle areas of weak performance and build on success. Patients will be able to use the information to make decisions about their care and to challenge their local trusts to improve services while championing those who excel. Commissioners will have an up-to-date and comparable measure to use to benchmark providers and use in contract discussions. Tracking trends will provide validation of where targeted improvements are most effective.

Inpatient

Period	Apr-13	May-13	Jun-13
FFT Score	71	72	72
No. Responses	73,671	87,102	93,466
Response Rate	21.7%	24.4%	27.1%

A&E

Period	Apr-13	May-13	Jun-13
FFT Score	49	55	54
No. Responses	38,988	53,184	71,643
Response Rate	5.6%	7.5%	10.3%

Post April Data Submission actions: All Trusts contacted directly, with a focus on sharing response rate best practice and mutual support and the trusts with the highest scores and response rates invited to share good practice.

NHS FFT June Data Summary – Headlines:

All 157 NHS acute trusts submitted data, with 56.1% achieving combined response rates of 15% or more. 89.8% of trusts achieved inpatient response rates of 15% or more and 26.4% of 144 trusts achieved A&E response rates of 15% or more. 45 Trusts had a significant improvement (>5 percentage points) in their combined response rates between months 2 and 3, 42 Trusts had a significant improvement in inpatient response rates and 39 had a significant improvement in A&E response rates.

Next Steps: Continuation of best practice records and publication and site visits where required. Regional relationship managers established by delivery team. Commenced working alongside Regional Leads and challenged Trusts.

Financial Performance

Executive Summary - Key Headlines										
	Year to date surplus					Forecast outturn surplus before further actions				
	Plan £m	Actual £m	Variance £m	Variance %	RAG	Plan £m	Forecast £m	Forecast Variance £m	Variance %	RAG
CCGs North	82.4	87.2	4.8	0.1%		239.5	237.9	(1.6)	0.0%	
CCGs Midlands and East	60.5	58.9	(1.6)	0.0%		184.5	172.3	(12.2)	(0.1%)	
CCGs London	32.4	28.2	(4.2)	(0.1%)		88.7	88.9	0.2	0.0%	
CCGs South	37.6	33.3	(4.3)	(0.1%)		102.3	99.2	(3.1)	0.0%	
Total CCGs	**212.9**	**207.6**	**(5.3)**	**0.0%**		**615.0**	**598.3**	**(16.7)**	**0.0%**	
Direct Commissioning:										
Specialised	36.7	13.8	(22.9)	(0.5%)		110.0	44.9	(65.1)	(0.5%)	
Armed Forces	0.0	0.0	0.0	0.0%		0.0	0.0	0.0	0.0%	
Health and Justice	0.0	0.0	0.0	0.0%		0.0	0.0	0.0	0.0%	
Primary Care	34.7	35.2	0.5	0.0%		98.3	113.1	14.8	0.1%	
Secondary and Community Dental	1.8	1.1	(0.7)	(0.3%)		4.9	0.6	(4.3)	(0.6%)	
Public Health	0.5	0.9	0.4	0.1%		1.5	(7.4)	(8.9)	(0.5%)	
Other	0.0	0.0	0.0	0.0%		0.0	0.0	0.0	0.0%	
Total Direct Commissioning	**73.7**	**51.0**	**(22.7)**	**(0.3%)**		**214.7**	**151.2**	**(63.5)**	**(0.2%)**	
Other	**0.0**	**119.5**	**119.5**	**0.0%**		**(296.0)**	**(296.0)**	**0.0**	**0.0**	
Social Care	**0.0**	**0.0**	**0.0**	**0.0%**		**0.0**	**0.0**	**0.0**	**0.0**	
TOTAL	**286.6**	**378.1**	**91.5**	**0.4%**		**533.7**	**453.5**	**(80.2)**	**(0.1%)**	

As noted in the Month 2 reporting, the basis of the above table is now that of surplus rather than expenditure. It is therefore possible to see from the table whether bodies are currently, and expecting to deliver, their planned surplus.

Clinical Commissioning Groups are forecasting surplus delivery broadly in line with plan, with a forecast £16.8 million shortfall, representing less than 0.05% of their total funding allocation.

For the year to date, we are reporting a shortfall of £22.8 million on delivery of the Specialised Commissioning surplus, arising chiefly in four area teams; it is expected that these pressures will persist and result in a full year shortfall of £65.2 million on planned surplus. This represents 0.5% of the total Specialised Commissioning funding allocation.

While the year to date surplus shortfall on Secondary and Community Dental is small at £0.7 million, a full year shortfall is forecast. This arises from funding transfers from CCGs to area teams that are yet to be agreed. The forecast surplus shortfall in Public Health arises in four area teams and relates to lower than planned growth funding, cost pressures and potential under-delivery of financial efficiency targets.

Finance Running Costs

NHS England Running Costs - July 2013

	Year to Date					FOT Before Further Actions				
	Plan £m	Actual £m	Var £m	Var %	RAG	Plan £m	Forecast £m	Var £m	Var %	RAG
Medical	4.73	3.66	1.07	22.55%	G	14.18	14.18	0.00	0.00%	G
Chief Nursing	3.70	2.77	0.93	25.14%	G	11.74	11.74	0.00	0.00%	G
Chief Operating Officer	104.11	100.35	3.76	3.61%	G	353.72	353.71	0.00	0.00%	G
Commissioning Development	2.13	1.47	0.66	30.90%	G	10.72	10.72	0.00	0.00%	G
Patients & Information	5.47	5.01	0.46	8.42%	G	20.51	20.51	0.00	0.00%	G
Finance	17.39	16.11	1.28	7.39%	G	42.18	42.18	0.00	0.00%	G
Policy	22.17	25.66	(3.50)	(15.78%)	R	66.50	66.50	0.00	0.00%	G
Human Resources	2.07	1.61	0.45	21.91%	G	7.41	7.41	0.00	0.00%	G
Reserves / transition costs	11.67	0.00	11.67	0.00%	G	105.64	105.64	0.00	0.00%	G
Other	8.33	8.33	0.00	0.00%	G	25.00	25.00	0.00	0.00%	G
Total NHS England Running Costs	**181.77**	**164.98**	**16.78**	**9.23%**	G	**657.61**	**657.61**	**0.00**	**0.00%**	G
Hosted services IQ	4.46	4.13	0.34	7.51%	G	13.39	13.39	0.00	0.00%	G
TOTAL	**186.23**	**169.11**	**17.12**	**9.19%**	G	**671.00**	**671.00**	**0.00**	**0.00%**	G

Commentary

Vacant posts across the organisation are resulting in underspends on pay costs across several of the Directorates.

The Policy Directorate has a year to date overspend due to higher than planned costs from NHS Property Services. An exercise is underway to analyse property costs incurred to date in order to clarify the likely full year position; amounts set aside in reserve for property costs are being used in the meantime to offset this overspend.

Finance Programme Costs

NHS England Programme Costs - July 2013

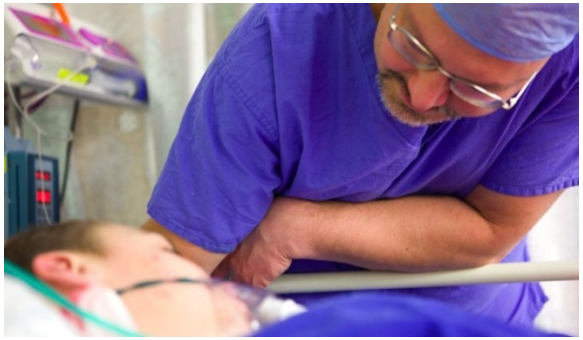
	Year to Date					FOT Before Further Actions				
	Plan £m	Actual £m	Var £m	Var %	RAG	Plan £m	Forecast £m	Var £m	Var %	RAG
Innovation Health & Wellbeing	16.67	8.15	8.52	**51.09%**	G	50.00	50.00	0.00	**0.00%**	G
Improvement Body	17.84	2.56	15.28	**85.64%**	G	53.53	53.53	0.00	**0.00%**	G
Medical (other)	11.63	0.93	10.70	**91.99%**	G	34.89	34.89	0.00	**0.00%**	G
Nursing	1.68	0.06	1.62	**96.21%**	G	5.06	5.06	0.00	**0.00%**	G
Clinical Networks and senates	11.61	6.87	4.75	**40.88%**	G	32.23	32.23	0.00	**0.00%**	G
Chief Operating Officer	19.73	0.01	19.73	**99.97%**	G	59.20	59.20	0.00	**0.00%**	G
Commissioning Development	1.66	1.49	0.17	**10.29%**	G	5.00	5.00	0.00	**0.00%**	G
Patients & Information	9.35	9.35	0.00	**0.00%**	G	84.68	84.68	0.00	**0.00%**	G
NHS Direct/111	26.58	27.19	(0.61)	**(2.29%)**	R	32.95	32.95	0.00	**0.00%**	G
Finance	0.83	0.83	0.00	**0.00%**	G	2.50	2.50	0.00	**0.00%**	G
Leadership Academy	23.30	23.35	(0.05)	**(0.21%)**	A	46.73	46.73	0.00	**0.00%**	G
Clinical Excellence Awards	0.00	0.00	0.00	**0.00%**	G	174.02	174.02	0.00	**0.00%**	G
Provider Support	68.00	47.30	20.70	**30.44%**	G	204.00	204.00	0.00	**0.00%**	G
Other budgets	(9.50)	0.00	(9.50)	**(100.00%)**	R	48.89	48.89	0.00	**0.00%**	G
Other Reserves	0.00	0.00	0.00	**0.00%**	G	31.41	31.41	0.00	**0.00%**	G
Contingency	30.98	0.00	30.98	**100.00%**	G	99.72	99.72	0.00	**0.00%**	G
Total NHS England Programme Costs	**230.38**	**128.09**	**102.28**	**44.40%**	G	**964.81**	**964.81**	**0.00**	**0.00%**	G

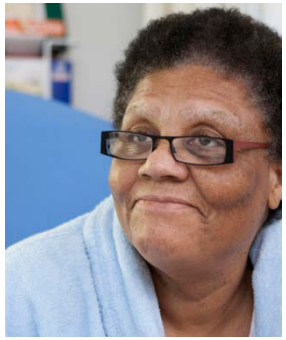
Commentary

Until further information is received on planned usage, the Contingency and Other reserves have been forecast to be used in month 12.

Programme budgets were forecast to be used steadily across the year. This assumption results in year to date underpends as activity on the programmes is yet to reach normal levels. Forecasts are currently being reviewed to understand likely actual positions for the full year.

Section D: Organisational Health





August 2013

THE NHS CONSTITUTION
the NHS belongs to us all

Workforce Reporting - Overview

The Board is aware that the majority of the staff of NHS England joined us under transfer arrangements from NHS employing bodies which were abolished 31 March 2013. The data on this section of our workforce is variable in quality.

Much of the data is reliant upon the analysis and interrogation of information held within the Electronic Staff Record (ESR). In order to enhance workforce data quality, a validation exercise will be undertaken during quarter three, which will involve reviewing and updating the personal information held on ESR for all our employees. This will enable us to improve reporting and to inform the development of key strategies, such as the *equality, diversity and inclusion in the workplace* strategy.

Therefore, whilst this section of the Board report represents an improvement from prior reporting, it does not yet provide the more holistic range of qualitative and quantitative data that we intend to report in future. In future, we plan also to include a range of benchmarking comparator data, drawn from the wider NHS and other sectors, against which NHS England's workforce outcomes can be considered.

For the report to the Board this month, the most significant expansion is the inclusion of the results of NHS England's first staff barometer. This provides an insight into the early experiences of the staff who have joined us.

As part of the organisational development of NHS England, this section of the report is likely to expand in the future beyond workforce related issues to encompass a range of other organisational health and internal service delivery areas.

NHS England

Becoming and Excellent Organisation - Future Board Reporting, what data will be available and when

REPORTING SUMMARY	National				Breakdown			
	Sept Update	13/14 Q2	13/14 Q3/4	14/15 onwards	Sept Update	13/14 Q2	13/14 Q3/4	14/15 onwards
ESTABLISHMENT REPORTING								
- post numbers	✓	✓	✓	✓	DR	DR	DR	DR / AT
- vacancy rates	✓	✓	✓	✓	DR	DR	DR	DR / AT
- secondment rates	✓	✓	✓	✓	DR	DR	DR	DR / AT
WORKFORCE REPORTING								
- turnover	×	×	✓	✓	×	×	DR	DR / AT
- sickness absence	×	×	✓	✓	×	×	DR	DR / AT
LEARNING AND DEVELOPMENT								
- uptake of mandatory training	×	×	✓	✓	×	×	DR	DR / AT
- L&D spend	×	×	✓	✓	×	×	DR	DR / AT
- average training days	×	×	✓	✓	×	×	DR	DR / AT
EQUALITY AND DIVERSITY								
- workforce E&D profile	×	×	✓	✓	×	×	DR	DR / AT
STAFF EXPERIENCE								
- staff barometer	✓	✓	✓	✓	DR / AT	DR / AT	DR / AT	DR / AT

DR – Directorate & Regional **AT** – Area Team

NHS England

Becoming and Excellent Organisation - Establishment reporting

Region / Functions	TOTAL POSTS			FILLING OF POSTS		VACANCY LEVELS		
	Posts in Establishment (including lift and shift)	Posts in Establishment (organisational structure only)	Lift and Shift Posts (post numbers based on headcount, not WTE)	Posts Filled to Date (n)	Posts Filled to Date (%)	Current Vacancy Rate (%) (July 2013)	Previous Vacancy Rate (%) (June 2013)	Trend (Upwards = improving; Downwards = worsening)
All NSC Directorates	1161	1161	0	929	80.0	20.0	23.4	↑
North Region	1896	1036	860	1765	93.1	6.9	7.6	↑
Midlands & East Region	1260	913	347	1198	95.1	4.9	5.8	↑
London Region	725	460	265	710	97.9	2.1	3.6	↑
South Region	1386	820	566	1290	93.1	6.9	7.3	↑
NHS Improving Quality	308	73	235	295	95.8	4.2	7.5	↑
NATIONAL	**6736**	4463	2273	**6187**	91.8	**8.2**	9.5	↑

NOTES:

1. The remaining vacant posts are currently being reviewed within individual regions and directorates. This work is to ensure that vacant posts are required as originally proposed or need to be utilised in a different manner. The current project to enhance establishment controls and align this to cost centres by the finance team will further improve reporting in this regard.
2. Of the total posts filled, 81 are secondments.
3. Posts filled takes into account any leavers between 1 April 2013 to 31 July 2013.

NHS England

Becoming and Excellent Organisation - Learning and Development

Providing its workforce with opportunities to develop through mandatory, and other job specific training is key to NHS England's efforts to become an excellent organisation.

Reporting of learning and development activity will be presented in future at regular board updates. This reporting, which is expected to commence during Quarter 3 / 4, will incorporate key statistics, which will enable comparisons with other employing organisations within the NHS and broader industry as follows:

- **Uptake of mandatory training**
- **Spend on learning and development**
- **Average days spent training**

NHS England

Becoming and Excellent Organisation - Workforce Equality & Diversity

NHS England has established a formal Equality and Diversity Strategy Group (EDSG, involving both non-executive and executive directors of the Board).

This group has now met twice, with the last meeting on 18 June 2013. Having discussed the principles for equality, diversity and inclusion in NHS England's workforce, the group identified a range of approaches that should seek to enhance and improve diversity within all levels of NHS England. Details were reported to the last board meeting.

A key part of the ESR data validation exercise that will be undertaken during quarter three will be to improve the level and quality of equality and diversity information recorded for the NHS England workforce. NHS England will undertake work to improve this data to enable effective reporting to the Board of the workforce profile in November 2013.

NHS England

Becoming and Excellent Organisation - Staff Experience

NHS England staff barometer feedback

Factors (Comprise a number of statements)	Strongly disagree or disagree	Neither agree nor disagree	Strongly agree or agree
Staff motivation (I look forward, am enthusiastic about work etc.)	10%	26%	64%
Job design (I am clear about goals, responsibilities etc.)	24%	18%	58%
Staff engagement (I have opportunities to show initiative, make suggestions, make improvements etc.)	16%	19%	65%
Staff satisfaction (Support from colleagues and managers, responsibility, freedom to operate etc.)	16%	21%	63%
View of organisation (Care of patients top priority, recommend as place to work etc.)	13%	28%	59%
OVERALL	**16%**	**22%**	**62%**

EMERGING THEMES

We undertook the Staff Barometer early in our establishment to help us understand and benchmark how staff feel we are doing as an organisation. At that time, 2,170 staff or 36 per cent of our staff undertook this online survey.

The results suggest a positive platform to build upon, of newly forming teams supported by good colleagues and managers, of staff who feel engaged and trusted to do their jobs, and with a vision and values that resonate strongly with many staff.

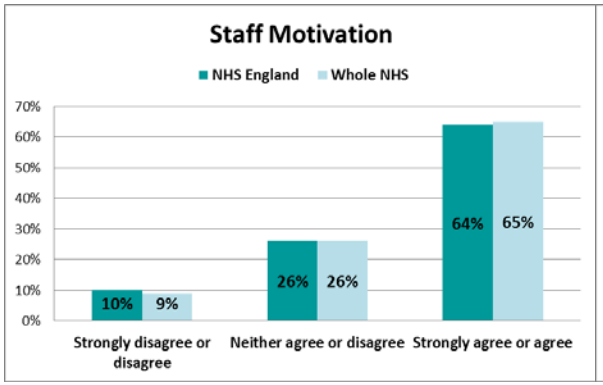
However, the enthusiasm is tempered by frustrations that persist as a result of transition, around some of the basics such as access to IT and office space and for some staff a difficult experience of the reorganisation and their induction into NHS England. Three keys areas for action emerge

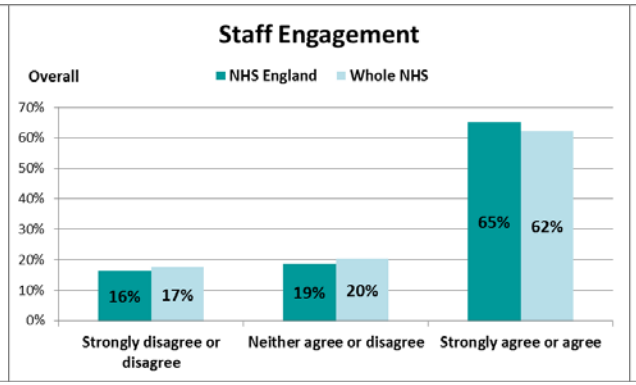
1. **Getting the basics right -** staff have asked that more is done to sort out IT, accommodation, desks, agile working, and to address any outstanding issues with expenses, finance, and procurement.
2. **Clarity of roles, objectives and workloads -** staff have asked we do more to support good performance reviews and personal development, for managers to take time to talk through roles and responsibilities, agree objectives and ensure that their staff are supported to use their skills.
3. **Tackling bureaucracy and hierarchy -** staff are keen to see more devolved decision making, and less bureaucratic processes, to reinforce the empowered, patient-focused culture.

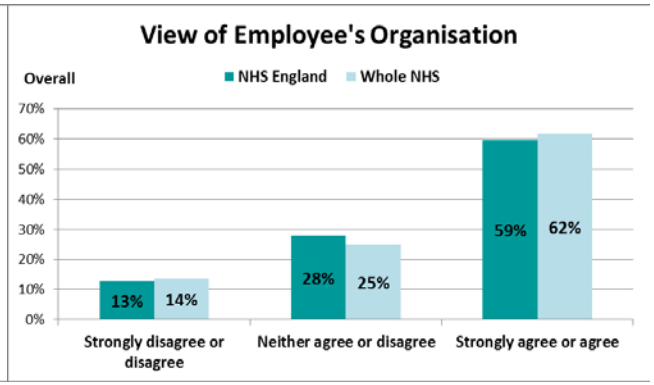
NHS England

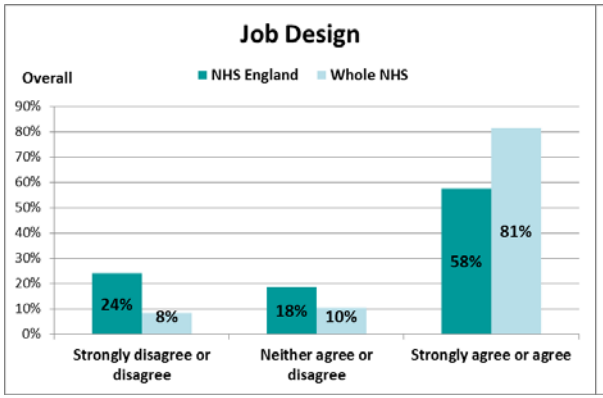
Becoming and Excellent Organisation

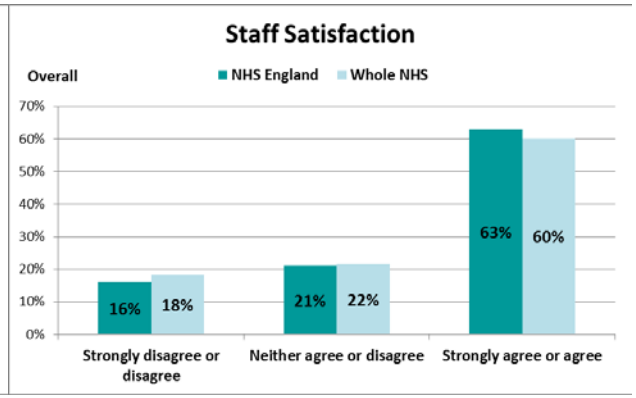
Staff Barometer results: Comparisons with the wider NHS workforce, based upon NHS Staff Survey 2012











- Based on a comparison with the NHS Staff Survey results of Autumn 2012, there is very little difference between the motivation of NHS England staff and staff in the wider service.
- NHS England staff have less clarity about their role than staff in the wider NHS. This may be expected as NHS England is a new organisation and is still in the transition period.
- NHS England staff are slightly more satisfied and engaged with their jobs than staff in the wider NHS.

Customer Contact Centre – up to 31st July 2013

Overall

- **75%** of calls continue to be answered within 45 seconds against a target of 80%.
- **79%** of all telephone calls creating a new general enquiry continue to be resolved at first point of contact.
- These performance figures reflect a stabilisation in service delivery when placed in the context of an increase since April 2013 of:-
- **16%** in calls;
- **53%** in emails and
- **118%** in letters.
- The stabilisation is enabling the backlog in general enquiries to be addressed, however, the increase in the levels of contact means that further progress towards targets at this time is limited without adding more resources.

General enquiries

- **29,003** have been received since 1st April 2013.
- **2,757** cases are still waiting action with the oldest enquiry not yet in progress dated 4th April 2013. The target is to clear the backlog by 20th September 2013 and this is currently on track to be achieved.

NHS England

Customer Contact Centre – up to 31st July 2013

Complaints

6,814 have been received since 1st April 2013.

1,172 are awaiting investigation, however they have been through initial triage for checking in relation to safeguarding and other issues.

2,175 have been assigned and marked as in progress with 73% of **new** cases that arrive being allocated to the area teams to resolve.

51% (3,467) of complaints have been resolved since 1st April 2013

27 working days is the average for resolving complaints with the oldest complaint not yet in progress being 20th June 2013.

Freedom of Information (FOI) requests

765 requests have been received since 1st April 2013.

55% of requests received continue to be responded to within 20 working days. However, the average clearance time for all FOI requests is 24 working days

There are currently no FOI requests that are not in progress.

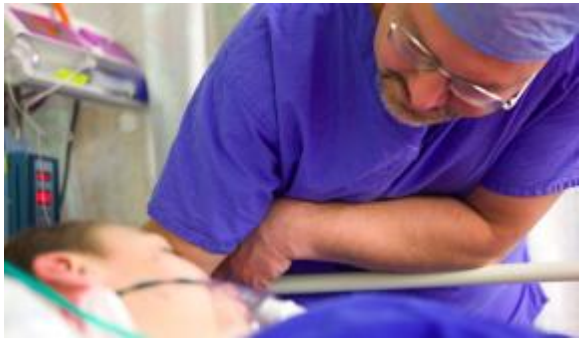
More detailed information on the performance of the Customer Contact Centre is being developed for the Quarter 2 report.

NHS England

Item

Section E: 11-Point Scorecard

Historic Data and Placeholders



NHS England Board Report
September 2013

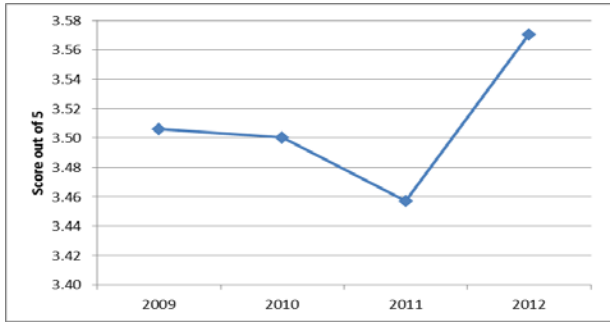
THE NHS CONSTITUTION
the NHS belongs to us all

Priority 2 - Motivated, positive NHS Staff

Staff friends and family test (Currently using "Staff recommendation of the trust as a place to work or receive treatment" average score from NHS Staff Survey as a proxy for Staff FFT)

		Score out of 5	% Change	Direction
Current Value	2012	3.57		
Change on previous year	2011	0.11	3.28%	↑
Long term change	N/A	N/A	N/A	

Desired direction: Up

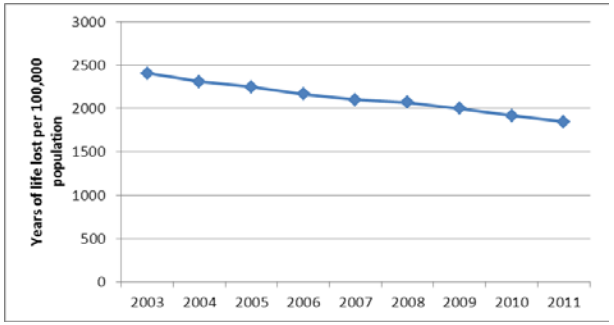


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1a.i: Potential Years of life lost from causes considered amenable to healthcare (Adults and Children – Females)

		Years of life lost per 100,000 population	% Change	Direction
Current Value	2011	1844		
Change on previous year	2010	-73	-3.78%	↓
Long term change	2003	-561	-23.32%	↓

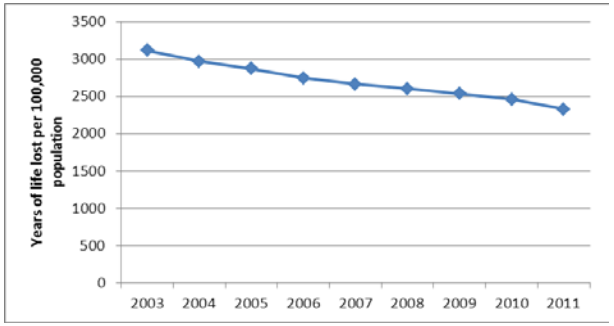
Desired direction: Down



NHS Outcomes Framework, indicator 1a.i: Potential Years of life lost from causes considered amenable to healthcare (Adults and Children – Males)

		Years of life lost per 100,000 population	% Change	Direction
Current Value	2011	2325		
Change on previous year	2010	-135	-5.49%	↓
Long term change	2003	-790	-25.35%	↓

Desired direction: Down

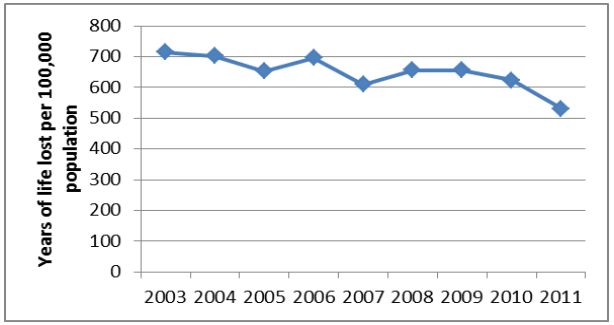


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1a.ii: Potential Years of Life Lost (PYLL) from causes considered amenable to health care (Children and Young People - Females)

		Years of life lost per 100,000 population	% Change	Direction
Current Value	2011	531		
Change on previous year	2010	-92	-14.79%	↓
Long term change	2003	-184	-25.75%	↓

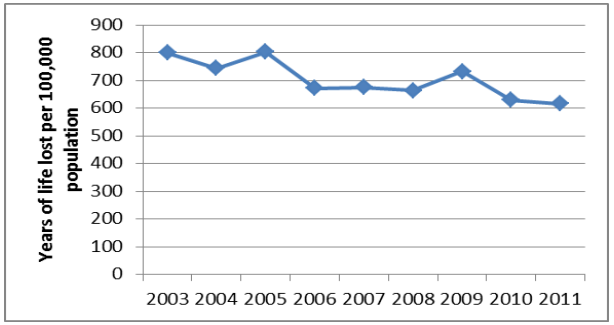
Desired direction: Down



NHS Outcomes Framework, indicator 1a.ii: Potential Years of Life Lost (PYLL) from causes considered amenable to health care (Children and Young People - Males)

		Years of life lost per 100,000 population	% Change	Direction
Current Value	2011	616		
Change on previous year	2010	-14	-2.18%	↓
Long term change	2003	-184	-22.96%	↓

Desired direction: Down

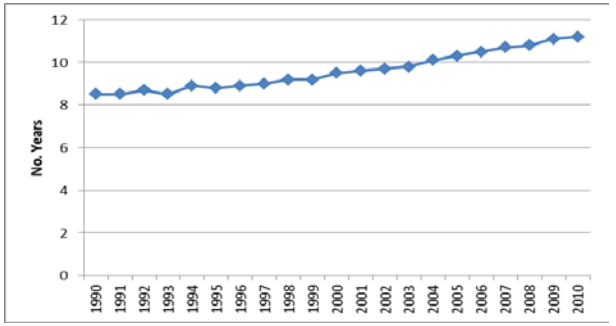


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1b.i: Life expectancy at 75 - males

		No. Years	% Change	Direction
Current Value	2010	11.2		
Change on previous year	2009	0.1	0.90%	↑
Long term change	1990	2.7	31.76%	↑

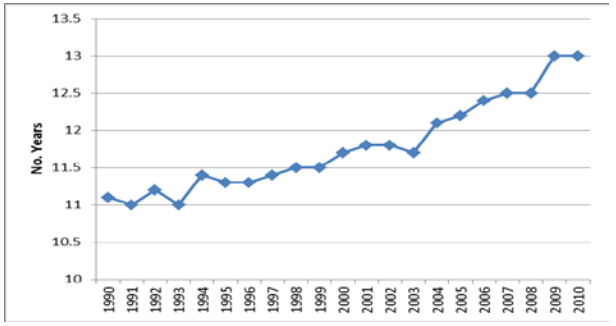
Desired direction: Up



NHS Outcomes Framework, indicator 1b.ii: Life expectancy at 75 - females

		No. Years	% Change	Direction
Current Value	2010	13.0		
Change on previous year	2009	0.0	0.00%	↔
Long term change	1990	1.9	17.12%	↑

Desired direction: Up

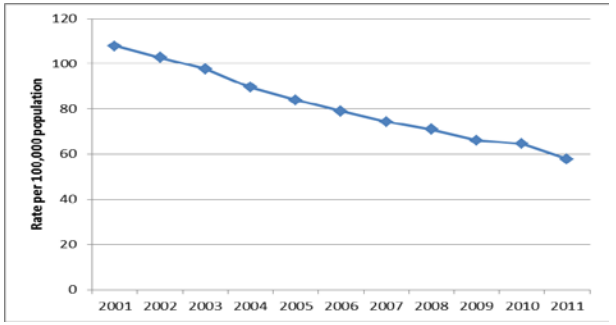


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.1: Under 75 mortality rate from cardiovascular disease

		Rate per 100,000 population	% Change	Direction
Current Value	2011	58.0		
Change on previous year	2010	-6.7	-10.36%	↓
Long term change	2001	-49.9	-46.27%	↓

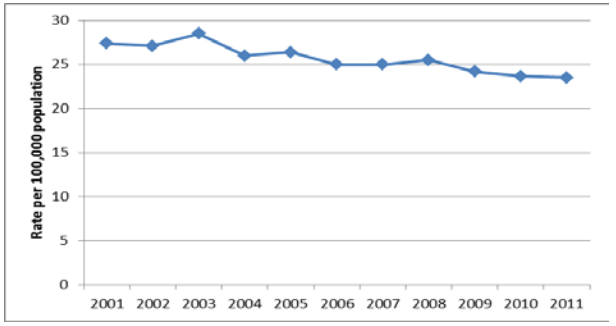
Desired direction: Down



NHS Outcomes Framework, indicator 1.2: Under 75 mortality from respiratory disease

		Rate per 100,000 population	% Change	Direction
Current Value	2011	23.5		
Change on previous year	2010	-0.1	-0.59%	↓
Long term change	2001	-3.9	-14.20%	↓

Desired direction: Down

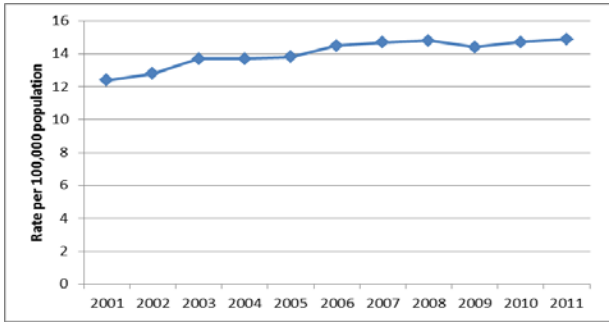


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.3: Under 75 mortality rate from liver disease

		Rate per 100,000 population	% Change	Direction
Current Value	2011	14.9		
Change on previous year	2010	0.2	1.29%	↑
Long term change	2001	2.5	20.16%	↑

Desired direction: Down



NHS Outcomes Framework, indicator 1.4.i:
One year survival from colorectal cancer

% surviving one-year

Period	2010	2011
Value	74.5%	74.4%
Change		-0.10%
% change		-0.13%

Desired direction: Up

NHS Outcomes Framework, indicator 1.4.ii:
Five year survival from colorectal cancer

% surviving five-years

Period	2010	2011
Value	54.9%	55.3%
Change		0.4%
% change		0.73%

Desired direction: Up

Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.4.iii: One-year survival from breast cancer

2011	% surviving 1 year	95.5%

NHS Outcomes Framework, indicator 1.4.iv: Five-year survival from breast cancer

% surviving five-years

Period	2010	2011
Value	83.7%	84.3%
Change		0.5%
% change		0.62%

Desired direction: Up

Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.4.v:
One-year survival from lung cancer

% surviving one-year

Period	2010	2011
Value	31.0%	31.6%
Change		1.9%
% change		0.6%

Desired direction: Up

NHS Outcomes Framework, Indicator 1.4.vi:
Five-year survival from lung cancer

% surviving five-years

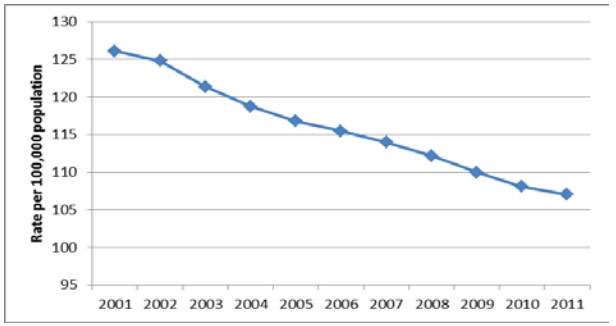
Period	2010	2011
Value	9.0%	9.8%
Change		0.8%
% change		8.9%

Desired direction: Up

NHS Outcomes Framework, indicator 1.4.vii: Under 75 mortality from cancer

		Rate per 100,000 population	% Change	Direction
Current Value	2011	107		
Change on previous year	2010	-1	-0.98%	↓
Long term change	2001	-19	-15.11%	↓

Desired direction: Down



Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.5: Excess under 75 mortality rates in adults with serious mental illness

Rate per 100,000 population

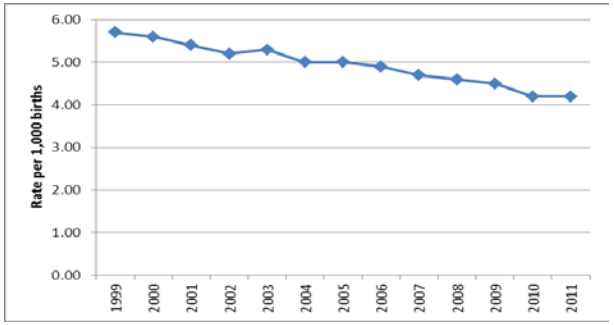
Period	2008-09	2009-10	2010-11
Value	946.6	891.30	921.2
Change		-55.30	29.9
% change		-5.8%	3.4%

Desired direction: Down

NHS Outcomes Framework, indicator 1.6.i: Infant mortality

		Rate per 1,000 births	% Change	Direction
Current Value	2011	4.2		
Change on previous year	2010	0.0	0.00%	↔
Long term change	1999	-1.5	-26.32%	↓

Desired direction: Down

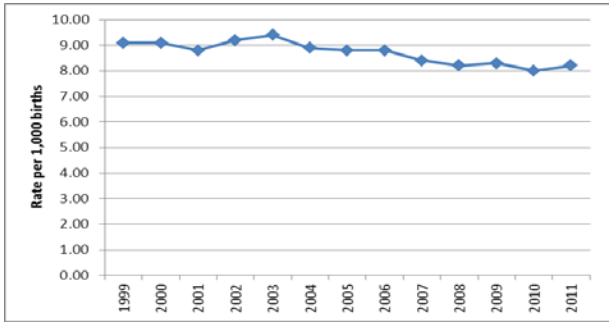


Priority 3: Preventing people from dying prematurely

NHS Outcomes Framework, indicator 1.6.ii: Neonatal mortality and still-births

		Rate per 1,000 births	% Change	Direction
Current Value	2011	8.2		
Change on previous year	2010	0.2	2.50%	↑
Long term change	1999	-0.9	-9.89%	↓

Desired direction: Down



NHS Outcomes Framework, indicator 1.6.iii: Five-year survival from all cancers in children

Indicator definition is still in development

NHS Outcomes Framework, indicator 1.7: Excess under 60 mortality in people with learning disabilities

Indicator calculation and data source still to be identified

Priority 4: Enhancing quality of life for people with long-term conditions

NHS Outcomes Framework, indicator 2: Health related quality of life for people with long-term conditions

Standardisation methodology still in development

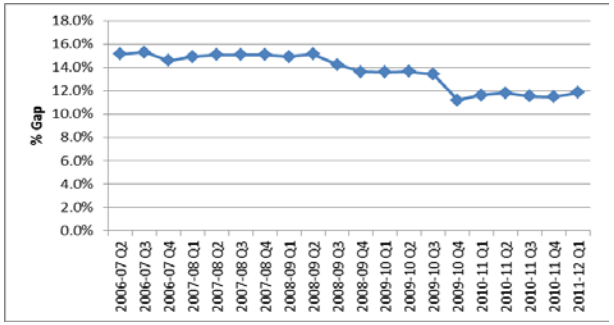
NHS Outcomes Framework, indicator 2.1: Proportion of people feeling supported to manage their own condition

Standardisation methodology still in development

NHS Outcomes Framework, indicator 2.2: Employment of people with long-term conditions

		% Gap	% Change	Direction
Current Value	2011-12 Q1	11.9%		
Change on previous year	2010-11 Q1	0.2%	2.07%	↑
Long term change	2006-07 Q2	-3.3%	-21.72%	↓

Desired direction: Down
Gap refers to the difference from the employment rate of all adults.

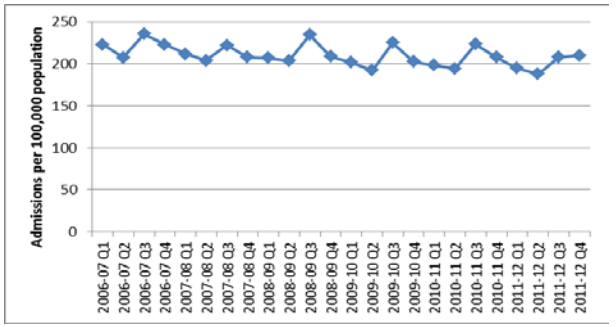


Priority 4: Enhancing quality of life for people with long-term conditions

NHS Outcomes Framework, indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)

		Admissions per 100,000 population	% Change	Direction
Current Value	2011-12 Q4	210.1		
Change on previous year	2010-11 Q4	2.3	1.11%	↑
Long term change	2003-04 Q1	-19.0	-8.29%	↓

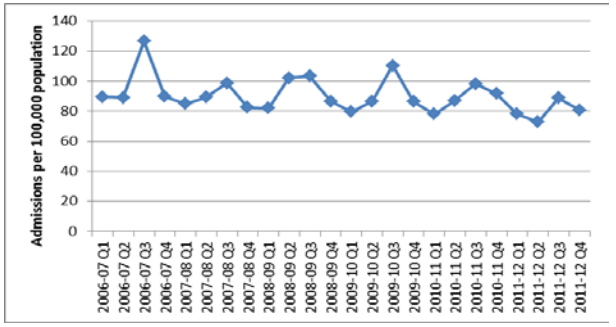
Desired direction: Down



NHS Outcomes Framework, indicator 2.3.ii: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

		Admissions per 100,000 population	% Change	Direction
Current Value	2011-12 Q4	80.7		
Change on previous year	2010-11 Q4	-10.9	-11.90%	↓
Long term change	2003-04 Q1	2.2	2.80%	↑

Desired direction: Down



Priority 4: Enhancing quality of life for people with long-term conditions

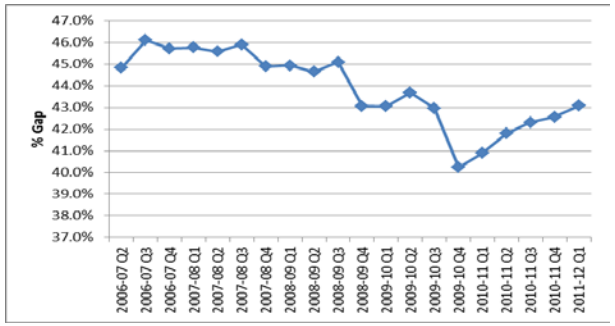
NHS Outcomes Framework, indicator 2.4: Health related quality of life for carers

Standardisation methodology still in development

NHS Outcomes Framework, indicator 2.5: Employment of people with mental illness

		% Gap	% Change	Direction
Current Value	2011-12 Q1	43.1%		
Change on previous year	2010-11 Q1	2.2%	5.33%	↑
Long term change	2006-07 Q2	-1.8%	-3.90%	↓

Desired direction: Down
Gap refers to the difference from the employment rate of all adults.

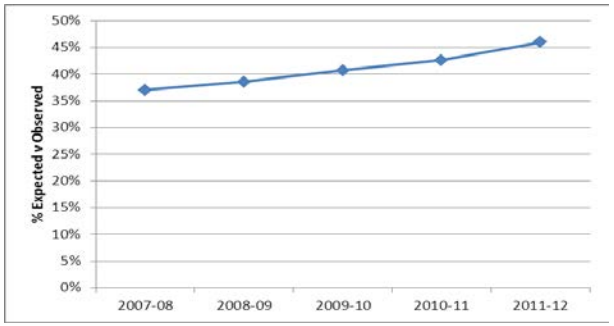


Priority 4: Enhancing quality of life for people with long-term conditions

NHS Outcomes Framework, indicator 2.6.i: Estimated diagnosis rate for people with dementia

		% Expected v Observed	% Change	Direction
Current Value	2011-12	46.0%		
Change on previous year	2010-11	3.4%	7.96%	↑
Long term change	2007-08	9.0%	24.32%	↑

Desired direction: Up



NHS Outcomes Framework, indicator 2.6.ii: A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

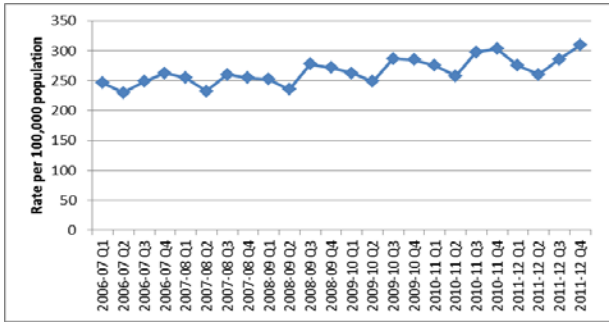
Indicator definition in development

Priority 5: Helping people to recover from episodes of ill health or following injury

NHS Outcomes Framework, indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission (all ages)

		Rate per 100,000 population	% Change	Direction
Current Value	2011-12 Q4	309.3		
Change on previous year	2010-11 Q4	6.3	2.08%	↑
Long term change	2003-04 Q1	102.2	49.35%	↑

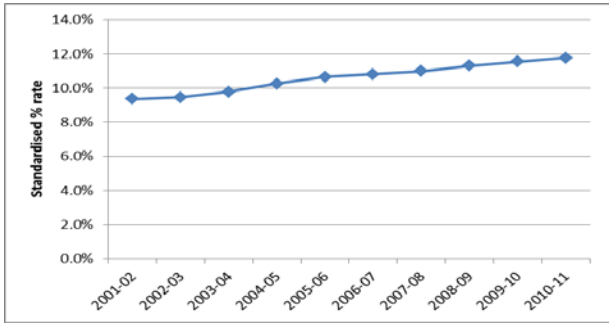
Desired direction: Down



NHS Outcomes Framework, indicator 3b: Emergency readmissions within 30 days of discharge from hospital

		Standardised % rate	% Change	Direction
Current Value	2010-11	11.8%		
Change on previous year	2009-10	0.2%	1.82%	↑
Long term change	2001-02	2.4%	25.78%	↑

Desired direction: Down

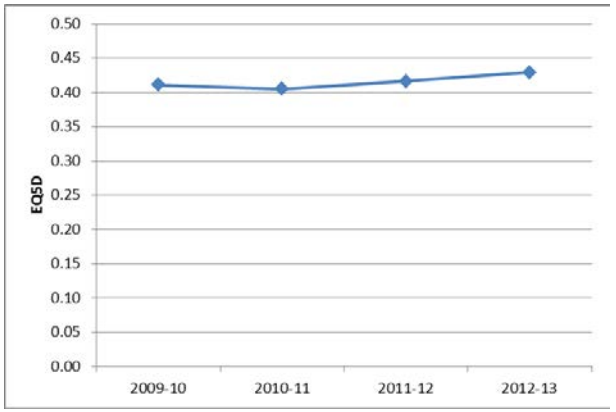


Priority 5: Helping people to recover from episodes of ill health or following injury

NHS Outcomes Framework, indicator 3.1.i:
Total health gain as assessed by patients for elective procedures: hip replacement

		Difference in pre and post operative EQ5D score	% Change	Direction
Current Value	2012-13**	0.4		
Change on previous year	2011-12*	0.01	3.13%	↑

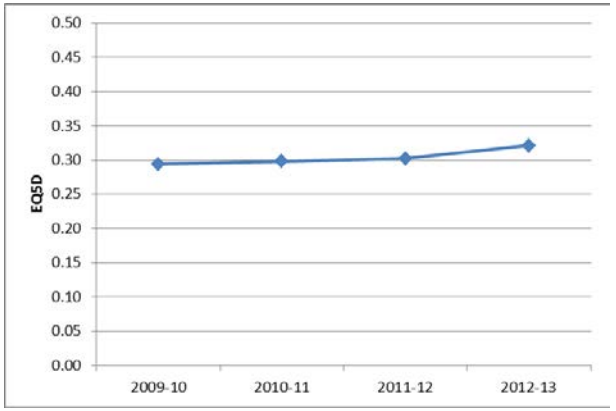
Desired direction: Up
* 2011-12 data is currently provisional
** 2012-13 data is provisional and currently only covers period Apr – Dec 2012



NHS Outcomes Framework, indicator 3.1.ii:
Total health gain as assessed by patients for elective procedures: knee replacement

		Difference in pre and post operative EQ5D score	% Change	Direction
Current Value	2012-13**	0.3		
Change on previous year	2011-12*	0.02	6.29%	↑

Desired direction: Up
* 2011-12 data is currently provisional
** 2012-13 data is provisional and currently only covers period Apr – Dec 2012

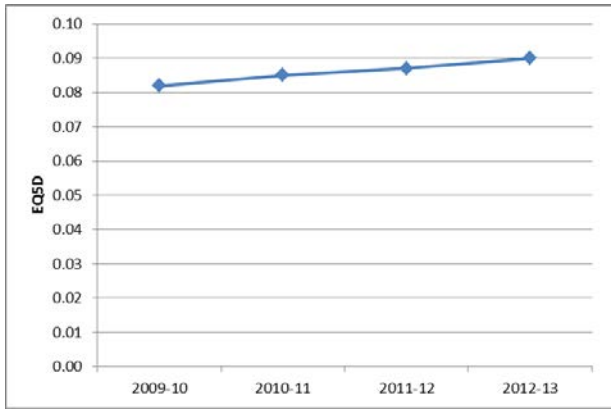


Priority 5: Helping people to recover from episodes of ill health or following injury

NHS Outcomes Framework, indicator 3.1.iii:
Total health gain as assessed by patients for elective procedures: groin hernia

		Difference in pre and post operative EQ5D score	% Change	Direction
Current Value	2012-13**	0.1		
Change on previous year	2011-12*	0.003	3.45%	↑

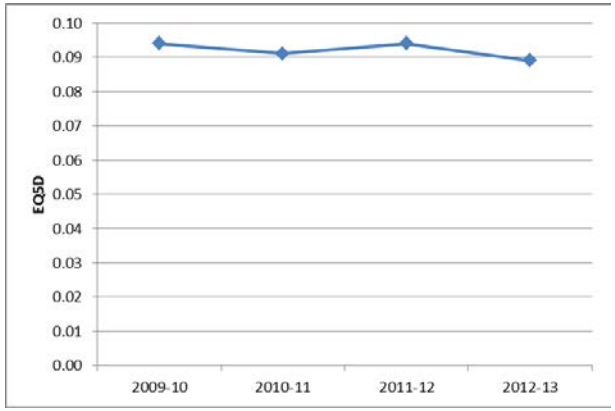
Desired direction: Up
* 2011-12 data is currently provisional
** 2012-13 data is provisional and currently only covers period Apr – Dec 2012



NHS Outcomes Framework, indicator 3.1.iv:
Total health gain as assessed by patients for elective procedures: varicose veins

		Difference in pre and post operative EQ5D score	% Change	Direction
Current Value	2012-13**	0.1		
Change on previous year	2011-12*	-0.005	-5.32%	↓

Desired direction: Up
* 2011-12 data is currently provisional
** 2012-13 data is provisional and currently only covers period Apr – Dec 2012



Priority 5: Helping people to recover from episodes of ill health or following injury

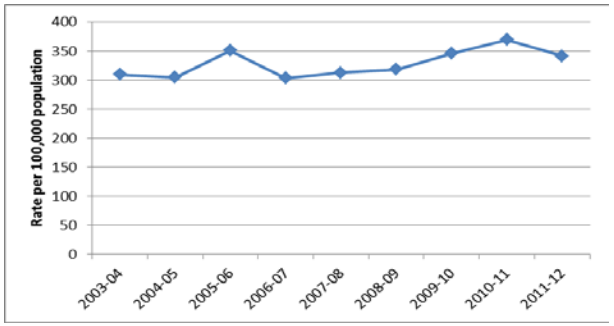
NHS Outcomes Framework, indicator 3.1.v: Total health gain as assessed by patients for elective procedures: psychological therapies

Indicator definition still in development

NHS Outcomes Framework, indicator 3.2: Emergency admissions for children with lower respiratory tract infections

		Rate per 100,000 population	% Change	Direction
Current Value	2011-12	341		
Change on previous year	2010-11	-28	-7.63%	↓
Long term change	2003-04	32	10.38%	↑

Desired direction: Down



NHS Outcomes Framework, indicator 3.3: Proportion of people who recover from major trauma

Indicator definition still in development

NHS Outcomes Framework, indicator 3.4: Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Data not yet available

Priority 5: Helping people to recover from episodes of ill health or following injury

NHS Outcomes Framework, indicator 3.5.i: The proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 30 days

2011	% recovering to previous levels of mobility/walking at 30 days	25.9%

Desired direction: Up

NHS Outcomes Framework, indicator 3.5.ii: The proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days

2011	% recovering to previous levels of mobility/walking at 120 days	48.7%

Desired direction: Up

Priority 5: Helping people to recover from episodes of ill health or following injury

NHS Outcomes Framework, indicator 3.6.i: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

Period	2011-12	2012-13
Value	82.7%	81.5%
Change		-1.2%

Desired direction: Up

NHS Outcomes Framework, indicator 3.6.ii: Proportion offered rehabilitation following discharge from acute or community hospital

Period	2011-12	2012-13
Value	3.2%	3.3%
Change		0.1%

Desired direction: Up

Priority 6: Ensuring people have a positive experience of care

NHS Outcomes Framework, indicator 4a.i:
Patient experience of primary care – GP services

% fairly good or very good

Period	2011-12	2012-13
Value	81.9%	86.7%
Change		4.8%
% change		8.9%

Desired direction: Up

NHS Outcomes Framework, indicator 4a.ii:
Patient experience of primary care – GP Out of Hours services

% fairly good or very good

Period	2011-12	2012-13
Value	70.9%	70.2%
Change		-0.65%
% change		-0.9%

Desired direction: Up

NHS Outcomes Framework, indicator 4a.iii: Patient experience of primary care – NHS Dental Services

% fairly good or very good

Period	2011-12	2012-13
Value	83.4%	84.0%
Change		0.6%
% change		0.7%

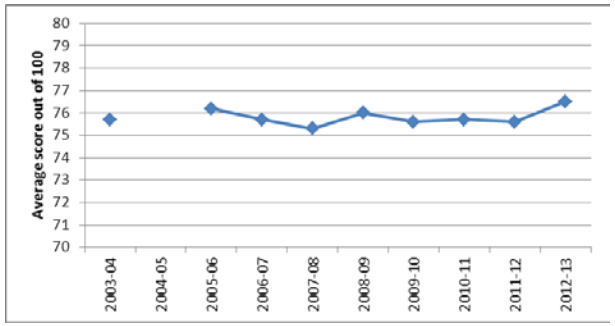
Desired direction: Up

Priority 6: Ensuring people have a positive experience of care

NHS Outcomes Framework, indicator 4b: Patient experience of hospital care

		Average score out of 100	% Change	Direction
Current Value	2012-13	76.50		
Change on previous year	2011-12	0.90	1.19%	↑
Long term change	2003-04	0.8	1.06%	↑

Desired direction: Up



NHS Outcomes Framework, indicator 4.1: Patient experience of outpatient services

Average score out of 100

Period	2009	2011
Value	78.6	79.5
Change		0.9

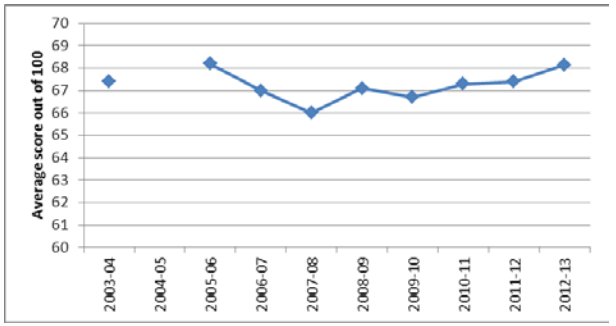
Desired direction: Up

Priority 6: Ensuring people have a positive experience of care

NHS Outcomes Framework, indicator 4.2: Responsiveness to in-patients' personal needs

		Average score out of 100	% Change	Direction
Current Value	2012-13	68.1		
Change on previous year	2011-12	0.7	1.10%	↑
Long term change	2003-04	0.7	1.10%	↑

Desired direction: Up



NHS Outcomes Framework, indicator 4.3:
Patient experience of A&E services

Average score out of 100

Period	2008	2012
Value	80.0	79.1
Change		-0.9
% change		-1.1%

Desired direction: Up

NHS Outcomes Framework, indicator 4.4.i:
Access to GP services

% fairly good or very good

Period	2011-12	2012-13
Value	79.1%	76.3%
Change		-2.8%
% change		-3.5%

Desired direction: Up

Priority 6: Ensuring people have a positive experience of care

NHS Outcomes Framework, indicator 4.4.ii
Access to NHS Dental Services

% that gained an appointment in the last 2 years

Period	2011-12	2012-13
Value	94.5%	93.0%
Change		-1.6%
% change		-1.7%

Desired direction: Up

NHS Outcomes Framework, indicator 4.5:
Women's experience of maternity services

2010	Average score out of 100	77.0

Desired direction: Up

NHS Outcomes Framework, indicator 4.6:
Bereaved carers' views on the quality of care
In the last 3 months of life

November 2010-June 2011	% good, excellent or outstanding	76.0%

Desired direction: Up

NHS Outcomes Framework, indicator 4.7:
Patients experience of community mental health services

Average score out of 100

Period	2010	2011	2012
Value	87.3	86.8	86.6
Change		-0.5	-0.02
% change		-0.5%	-0.2%

Desired direction: Up

Priority 6: Ensuring people have a positive experience of care

NHS Outcomes Framework, indicator 4.8: Improving children and young people's experience of healthcare

Indicator definition still in development

NHS Outcomes Framework, indicator 4.9: Improving people's experience of integrated care

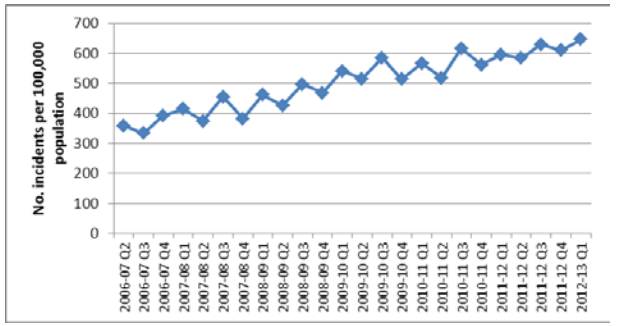
Indicator definition still in development

Priority 7: Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Outcomes Framework, indicator 5a: Patient Safety incident reporting

		No. incidents per 100,000 population	% Change	Direction
Current Value	2012-13 Q1	646		
Change on previous year	2011-12 Q1	51	8.48%	↑
Long term change	2003-04 Q3	645	215133%	↑

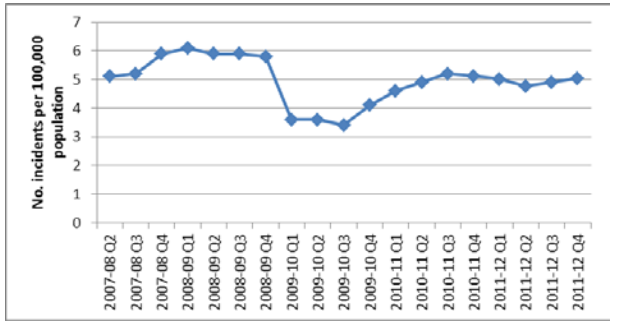
Desired direction: Up. At present the key priority is to improve the reporting of patient safety issues. This will drive this data upwards. Once this transition period is complete we will want incidents to fall.



NHS Outcomes Framework, indicator 5b: Safety incidents resulting in severe harm or death

		No. incidents per 100,000 population	% Change	Direction
Current Value	2011-12 Q4	5.0		
Change on previous year	2010-11 Q4	-0.1	-1.62%	↓
Long term change	2007-08 Q2	-0.1	-1.24%	↓

Desired direction: Down



Priority 7: Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Outcomes Framework, Indicator 5c: Hospital deaths attributable to problems in care

Indicator definition still in development

NHS Outcomes Framework, Indicator 5.1: Incidence of hospital-related venous thromboembolism (VTE)

Technical issues with indicator still being refined

NHS Outcomes Framework, Indicator 5.3: Incidence of newly-acquired category 2, 3 and 4 pressure ulcers

Technical issues with indicator still being refined

Priority 7: Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Outcomes Framework, Indicator 5.4: Incidence of medication errors causing serious harm

Rate per 100,000 population

Period	2008	2009	2010
Value	0.77	0.61	0.52
Change		-0.16	-0.09
% change		-20.8%	-14.8%

Desired direction: Down

NHS Outcomes Framework, Indicator 5.5: Admission of full-term babies to neonatal care:

2010	Proportion of all full-term babies who were admitted to neonatal care	5.1%

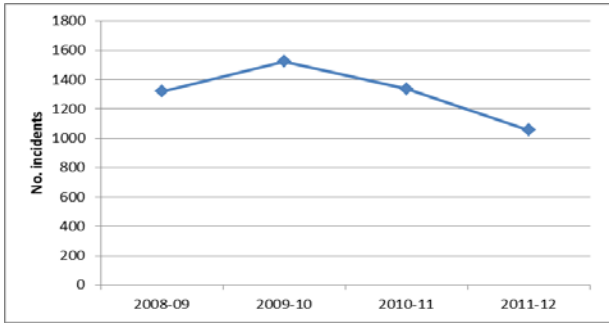
Desired direction: Down

Priority 7: Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Outcomes Framework, Indicator 5.6: Incidence of harm to children due to 'failure to monitor'

		No. incidents	% Change	Direction
Current Value	2011-12	1057		
Change on previous year	2010-11	-280	-20.94%	↓
Long term change	N/A	N/A	N/A	

Desired direction: Down

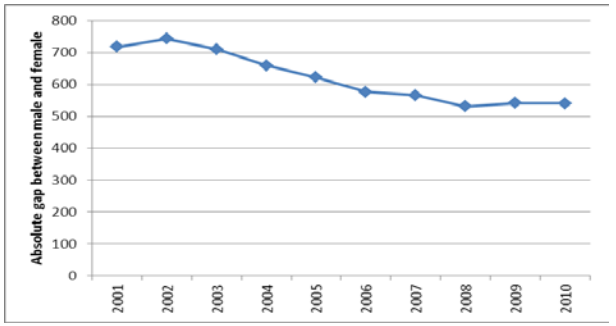


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 1a.i: Potential Years of Life Lost (PYLL) from causes considered amenable to health care (Adults and Children) - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2010	540.8		
1 Year Change	2009	-1.2	-0.23%	↓
5 Year Change	2005	-82.0	-13.17%	↓

Desired direction: Down



NHS Outcomes Framework, Indicator 1a.i: Potential Years of Life Lost (PYLL) from causes considered amenable to health care (Adults and Children) – Deprivation Analysis

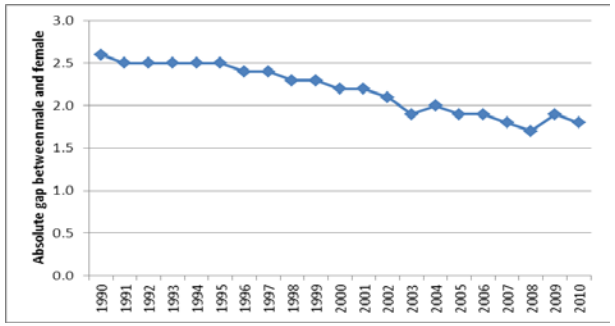
		Relative change in slope index of inequality	Direction
1 Year Change	2010-2011	-11.3%	↓
5 Year Change	2006-2011	-13.7%	↓

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 1b: Life expectancy at 75 - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2010	1.8		
1 Year Change	2009	-0.1	-5.26%	↓
5 Year Change	2005	-0.1	-5.26%	↓



Desired direction: Down

NHS Outcomes Framework, Indicator 1b.i: Life expectancy at 75 (Male) - Deprivation analysis

		Relative change in slope index of inequality	Direction
1 Year Change	2007-09 to 2008-10	-5.1%	↓
5 Year Change	2003-05 to 2008-10	5.0%	↑

Desired direction: Down

NHS Outcomes Framework, Indicator 1b.i: Life expectancy at 75 (Female) - Deprivation analysis

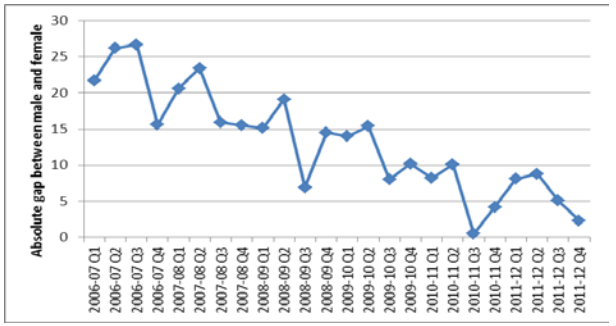
		Relative change in slope index of inequality	Direction
1 Year Change	2007-09 to 2008-10	-1.5%	↓
5 Year Change	2003-05 to 2008-10	21.5%	↑

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2011-12 Q4	2.3		
1 Year Change	2010-11 Q4	-1.9	-45.24%	↓
5 Year Change	2006-07 Q4	-13.3	-85.26%	↓



Desired direction: Down

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - Deprivation analysis

		Relative change in slope index of inequality	Direction
1 Year Change	2009-10 to 2010-11	7.0%	↑
5 Year Change	2005-06 to 2010-11	6.0%	↑

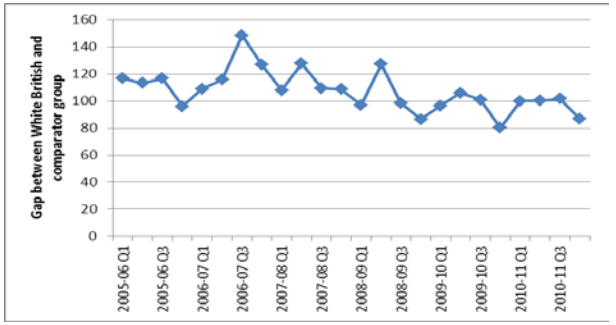
Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - White British compared to Asian or Asian British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	86.8		
1 Year Change	2009-10 Q4	6.7	8.34%	↑
5 Year Change	2005-06 Q4	-9.2	-9.59%	↓

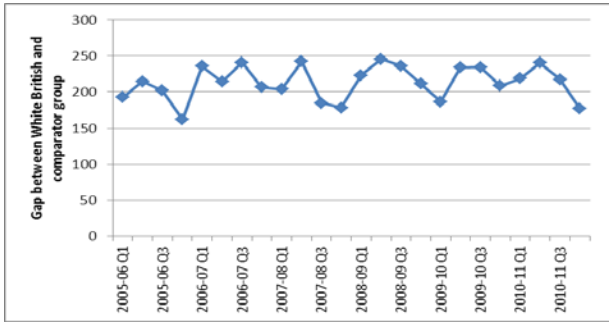
Desired direction: Down



NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - White British compared to Black or Black British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	176.6		
1 Year Change	2009-10 Q4	-31.8	-15.25%	↓
5 Year Change	2005-06 Q4	15.2	9.42%	↑

Desired direction: Down

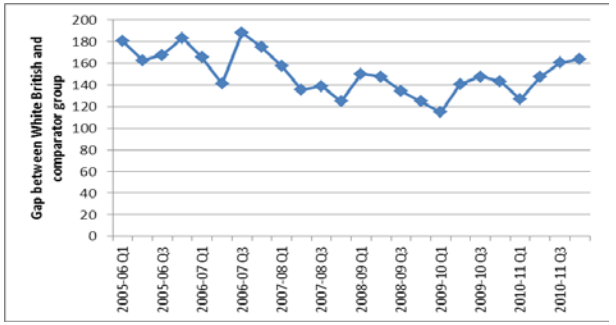


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - White British compared to Other Ethnic Group

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	163.7		
1 Year Change	2009-10 Q4	20.6	14.40%	↑
5 Year Change	2005-06 Q4	-19.3	-10.52%	↓

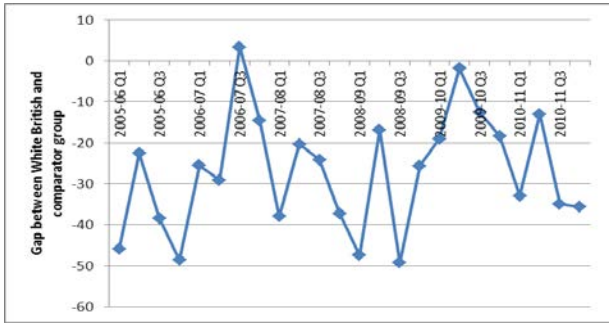
Desired direction: Down



NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - White British compared to Mixed

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	-35.7		
1 Year Change	2009-10 Q4	17.4	94.82%	↑
5 Year Change	2005-06 Q4	-12.9	-26.54%	↓

Desired direction: Down

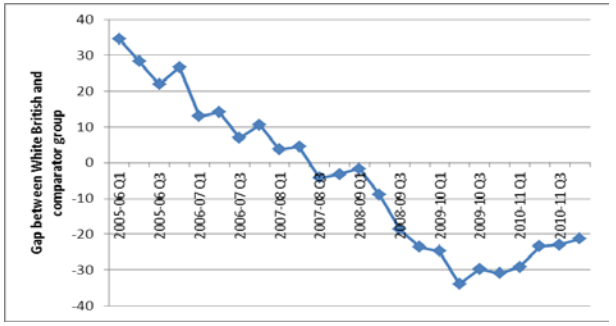


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - White British compared to Other White ethnicity

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	-21.3		
1 Year Change	2009-10 Q4	-9.7	-31.34%	↓
5 Year Change	2005-06 Q4	-5.5	-20.56%	↓

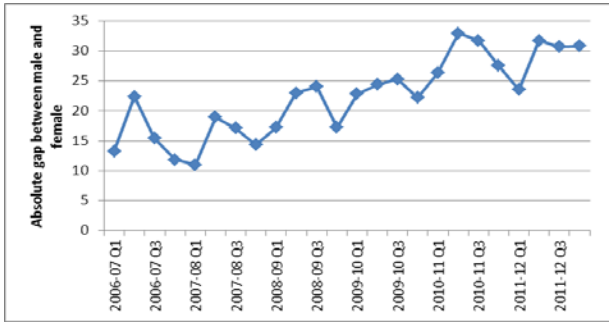
Desired direction: Down



NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2011-12 Q4	30.8		
1 Year Change	2010-11 Q4	3.3	12.00%	↑
5 Year Change	2006-07 Q4	19.0	161.02%	↑

Desired direction: Down



Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - Deprivation analysis

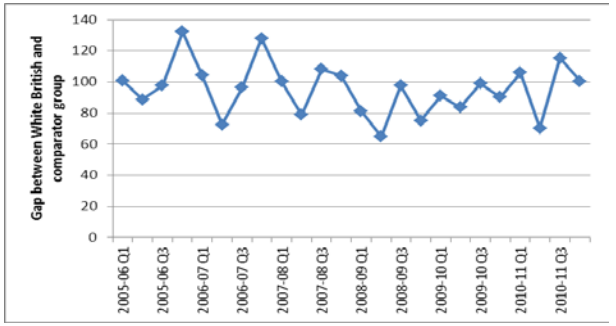
		Relative change in slope index of inequality	Direction
1 Year Change	Q4 09-10 to Q4 10-11	4.2%	↑
5 Year Change	Q4 05-06 to Q4 10-11	-1.5%	↓

Desired direction: Down

NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - White British compared to Asian or Asian British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	100.7		
1 Year Change	2009-10 Q4	10.4	11.55%	↑
5 Year Change	2005-06 Q4	-31.7	-23.92%	↓

Desired direction: Down

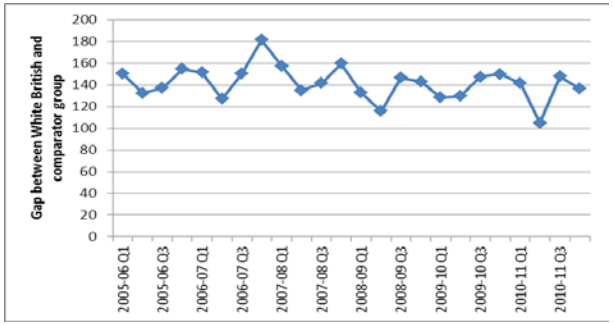


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - White British compared to Black or Black British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	136.4		
1 Year Change	2009-10 Q4	-13.4	-8.95%	↓
5 Year Change	2005-06 Q4	-18.1	-11.74%	↓

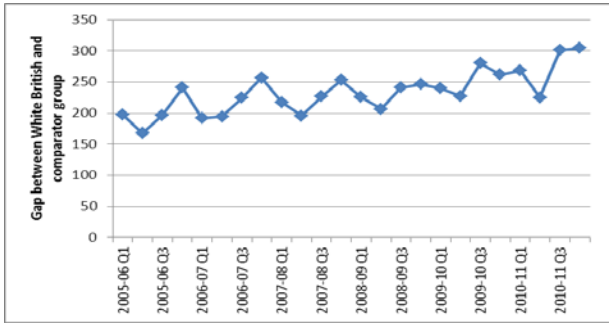
Desired direction: Down



NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - White British compared to Other Ethnic Group

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	304.6		
1 Year Change	2009-10 Q4	42.7	16.33%	↑
5 Year Change	2005-06 Q4	63.4	26.29%	↑

Desired direction: Down

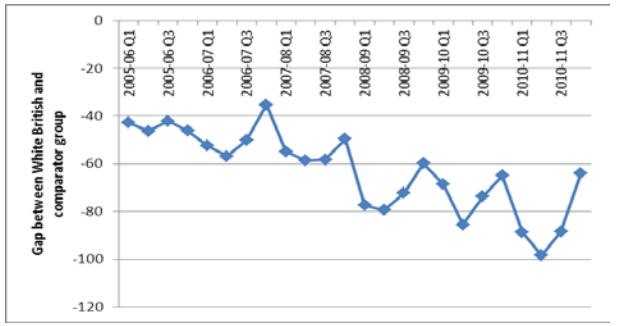


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - White British compared to Mixed

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	-63.95		
1 Year Change	2009-10 Q4	-0.95	-1.46%	↓
5 Year Change	2005-06 Q4	17.78	38.49%	↑

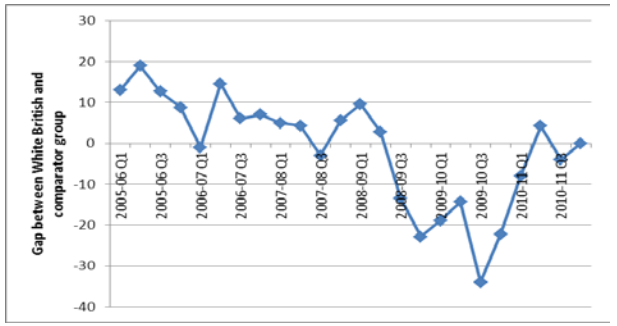
Desired direction: Down



NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission - White British compared to Other White ethnicity

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2010-11 Q4	-0.05		
1 Year Change	2009-10 Q4	-22.15	-99.77%	↓
5 Year Change	2005-06 Q4	-8.75	-99.43%	↓

Desired direction: Down

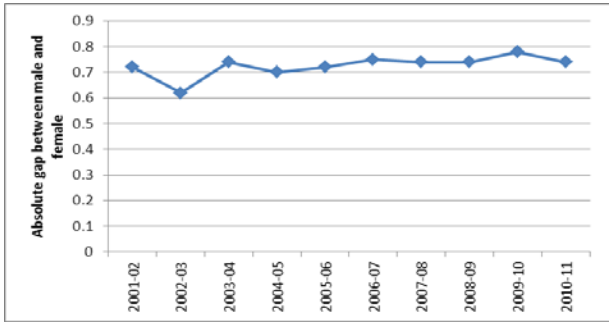


Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 3b: Emergency readmissions within 30 days of discharge from hospital - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2010-11	0.74		
1 Year Change	2009-10	-0.04	-5.13%	↓
5 Year Change	2005-06	0.02	2.78%	↑

Desired direction: Down



NHS Outcomes Framework, Indicator 3b: Emergency readmissions within 30 days of discharge from hospital - Deprivation analysis

		Relative change in slope index of inequality	Direction
1 Year Change	2009-10 to 2010-11	6.5%	↑
5 Year Change	2005-06 to 2010-11	-1.8%	↓

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - Gender comparison

		Absolute gap between male and female	% Change	Direction
Current Value	2012-13	1.0%		
1 Year Change	2011-12	-0.1%	-10.66%	↓
5 Year Change	N/A	N/A	N/A	

Desired direction: Down

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - Deprivation Analysis

		Relative change in slope index of inequality	Direction
1 Year Change	2011-12 to 2012-13	5.6%	↑
5 Year Change	N/A	N/A	

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - White British compared to Asian or Asian British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2012-13	-11.0%		
1 Year Change	2011-12	-0.8%	8.27%	↑
5 Year Change	N/A	N/A	N/A	

Desired direction: Down

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - White British compared to Black or Black British

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2012-13	-0.4%		
1 Year Change	2011-12	0.0%	7.82%	↑
5 Year Change	N/A	N/A	N/A	

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - White British compared to Other Ethnic Group

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2012-13	-4.6%		
1 Year Change	2011-12	1.4%	-23.37%	↓
5 Year Change	N/A	N/A	N/A	

Desired direction: Down

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - White British compared to Mixed

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2012-13	-6.7%		
1 Year Change	2011-12	-0.5%	8.10%	↑
5 Year Change	N/A	N/A	N/A	

Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services - White British compared to Other White ethnicity

		Gap between White British and comparator group	% Change on size of gap	Direction
Current Value	2012-13	-5.8%		
1 Year Change	2011-12	0.0%	-0.27%	↓
5 Year Change	N/A	N/A	N/A	

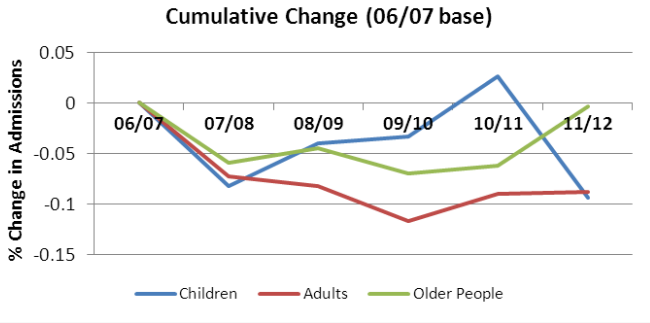
Desired direction: Down

Priority 8 - Promoting equality and reducing inequalities in health outcomes

Analysis of age has been carried out to show how the indicators for different age groups change over time. We expect utilisation to differ across age groups, therefore it is not appropriate to measure the gap between groups as we have above. Therefore this analysis shows changing inequality of resource utilisation between different age groups over time.

NHS Outcomes Framework, Indicator 2.3.i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions – Age Analysis

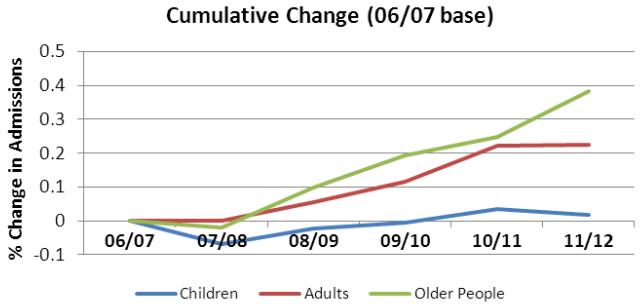
	1 Yr Change %	5 Yr Change %
Children	-11.7%	-9.3%
Adults	0.2%	-8.8%
Older People	6.2%	-0.3%



Priority 8 - Promoting equality and reducing inequalities in health outcomes

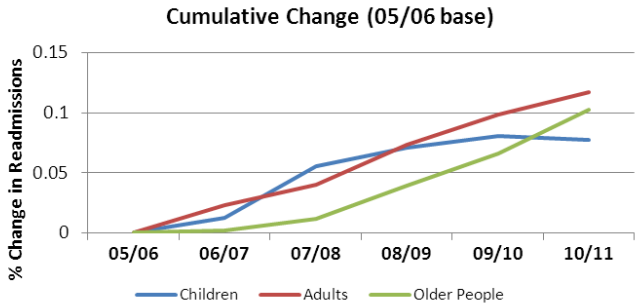
NHS Outcomes Framework, Indicator 3a: Emergency admissions for acute conditions that should not usually require hospital admission (all ages) – Age Analysis

	1 Yr Change %	5 Yr Change %
Children	-1.8%	1.7%
Adults	0.4%	22.6%
Older People	10.9%	38.2%



NHS Outcomes Framework, Indicator 3b: Emergency readmissions within 30 days of discharge from hospital – Age Analysis

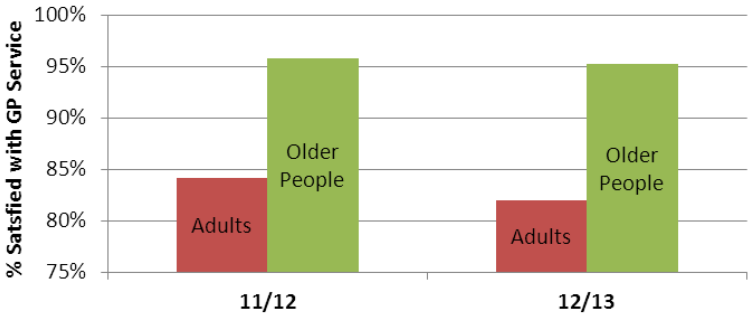
	1 Yr Change %	5 Yr Change %
Children	-0.3%	7.7%
Adults	1.7%	11.7%
Older People	3.4%	10.2%



Priority 8 - Promoting equality and reducing inequalities in health outcomes

NHS Outcomes Framework, Indicator 4a.i: Patient experience of primary care - GP Services – Age Analysis

	1 Yr Change %
Adults	-2.5%
Older People	-0.6%



Priority 10 - Becoming and excellent organisation

360 degree feedback

Data not yet available

Board Assurance Framework Update

1. The executive risk management group met on 25 July and 29 August 2013 to review the Board Assurance Framework (BAF), to confirm actions being undertaken and check assurances.

2. The changes to the BAF since the last Board meeting on 18 July 2013 are:

- amendments to the framework of the BAF, which provide additional guidance to support the understanding of the columns, addition of a further scoring column for current residual risk and a trend/direction arrow

- the following risks have been re-written to provide a greater clarity of understanding, as a result of a detailed review by National Directors:
  - risk number 1 - Strategy
  - risk number 5 - Clarity of roles
  - risk number 9 - Primary care
  - risk number 14 - Commissioning support services
  - risk number 16 - World class customer service
  - risk number 26 - Embedding outcomes
  - risk number 27 - Development of commissioning
  - risk number 28 - Innovation and research

- risk number 20 (financial resources) has been re-worded and incorporated into a new risk established at risk number 33 (capacity and Capability)

- a further two new risks have been added entitled, ‘Immature Systems’ and ‘Processes and External Partners’- priorities and whole system approach, at risk numbers 30 and 32 respectively. The risk relating to external partners has been added following a request from the Board

- the above alterations, the merging of risks and newly written risks, are a result of discussions at the executive risk management group which identified risk themes that should be reflected in the BAF. These additional risk themes reflected are:

  - The potential for fragmentation given the number of roles in the system
  - Activity and contract monitoring information
  - Reconfiguration
  - The maturity of systems and processes
  - Capacity and capability within NHS England

NHS England Board Assurance Framework (incorporating strategic risks) as at 29 August 2013

These are the significant risks directly associated with delivering the NHS England Business Plan. Also included are operational risks that have emerged through directorate reporting and escalation in terms of significance for the organisation

Risk Owner	Risk Ref	Potential Risk Description	Business Plan Score Card Priority											Initial Risk Score (see note 1)			Mitigating Actions in Place	Internal Assurance	External Assurance	Current Residual Risk Score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion Date for Actions	Anticipated Risk Score Following Mitigation (see note 3)		
		Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	1 - Satisfied patients	2 - Motivated, positive NHS staff	3 - Domain 1, preventing people	4 - Domain 2, enhancing quality of	5 - Domain 3, Helping people recover from	6 - Domain 4, Positive experience of care	7 - Domain 5, Safe environment &	8 - Promoting equality and reducing	9 - NHS constitution rights and pledges	10 - Becoming an excellent organisation	11. High quality financial management	Impact	Likelihood	RAG Status	*Systems and processes that are in place and operating that mitigate this risk*	*Internal evidence that this risk is being effectively managed (e.g. Board reporting, subcommittee and internal audit committee reviews)*	*External evidence that this risk is being effectively managed (e.g. planned or received external audit reviews)*	Impact	Likelihood	RAG Status		*Additional actions required to mitigate this risk further*	*For each further mitigating actions a completion date must be provided*	Impact	Likelihood	RAG Status
PUTTING PATIENTS FIRST																												
National Director: Policy Supported by: Chief Operating Officer and Chief Financial Officer	**1**	**Strategy:** There is a risk that the context in which NHS England is operating will undermine the ability to develop and lead visionary programmes of work, needed to improve outcomes for patients into the future. This is in relation to the financial environment, potential for future service development, the political context and the relatively early development of relationships across the new health and care system.	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	5	4	R	1. NHS England, with partners, is leading a "7 products" strategy programme. 2. Working arrangements in place to share and agree NHS England strategic analysis with partners. 3. Post spending review work with Local Government Association (LGA) to agree conditions, including political buy in for use of integration fund. 4. 'Call to Action' process to gain local ownership for actions through CCG's.	1. Programme governance established. 2. Regular reporting to the Board. 3. Included in the internal audit plan for review.	1. Arm's Length Body (ALB) joint executive group.	4	4	R	⇩	1. Joint review with Monitor, Care Quality Commission (CQC) and NHS Trust Development Authority (NHS TDA) of multi year planning approach.	1. 30/08/2013	4	3	AR
Chief Financial Officer	**2**	**Financial risk in partner organisations:** There is a risk that in some areas, serious financial difficulties elsewhere in the health and social care sector (e.g. provider or social care organisations) leads to an adverse impact on commissioners (CCGs and NHS England) either financially or operationally.									✓		✓	4	4	R	1.The shared financial agreement between NHS England, Monitor and the Department of Health (DH) considers health sector wide financial positions. 2. The planning process for 2013/14 included an on-going process of triangulation with the NHS Trust Development Authority (NHS TDA) of commissioner and provider plans. 3. NHS England has agreed a set of principles under which support may be provided to challenged Trusts outside of Public by Results (PbR) rules. 4. Local Authority & social care - Transfer of £859m to Local Authorities for social care in 2013/14 is a year on year increase and is overseen locally.	1. Providers: over the last 2 months NHS England and NHS TDA Executives have met to discuss and agree support to financially challenged Trusts in line with the agreed principles. The risks of both provider and social care financial positions impacting on CCGs or NHS England are most likely to be clarified in the over-performance of acute contracts. 2. Acute activity over-performance will be included as a risk item reported to Finance and Investment Committee (FIC).	None identified.	4	3	AR	⇩	1. NHS England wide programme to ensure appropriate activity information is available, overseen by the Operations Directorate. 2. Timely and relevant information on activity trends is available to enable corrective action to be taken especially in direct commissioning.	1. 30/09/2013 2. 30/09/2013	4	3	AR
Chief Operating Officer Supported by National Directors: Patients and Information, Policy & Chief Financial Officer	**3**	**Direct Commissioning:** There is a risk that underdeveloped direct commissioning processes do not discharge specialised commissioning responsibilities effectively. This could result in loss of potential outcome benefits and financial risk.	✓		✓	✓	✓	✓	✓	✓	✓		✓	4	4	R	1. Approach to the Single Operating Model has been reinforced. 2. Board approved governance arrangements of committee and oversight groups. 3. Implementation of single operating models in progress. 4. Some progress in aligning staff from national support centre to contribute to direct commissioning. 5. Direct commissioning assurance framework under development. 6. Regional Director leads identified for each aspect. 7. Commissioning Support Unit service level agreements in place with steering group.	1. Board development session 17 July 2013. 2. The Board has approved a Direct Commissioning Committee with Non - Executive Directors identified. 3. Specialised Commissioning oversight group. 4. Included in the internal audit plan for review.		3	4	AR	⇩	1. Dedicated project team to be established through rapid mobilisation of resources and high profile attention by the Executive Team. 2. Work underway to clarify roles and responsibilities across matrix. 3. Assurance framework for direct commissioning under development.	1. 31/03/2014 2. 31/03/2014 3. 31/03/2014	4	3	AR
Chief Operating Officer	**4**	**Urgent Care Demand:** There is a risk that increasing demand for urgent and emergency services leads to a threat to delivery of key operational standards which are a marker for quality of care of patients.					✓	✓	✓		✓			4	4	R	1. NHS A&E Improvement plan guidance published on 9 May 2013 on NHS England website. 2. A&E Improvement plan which has led to Urgent Care Boards being established in local health systems along with regional and national tripartite groups for oversight of recovery and improvement plans. 3. This work is also informed by Emergency Care Intensive Support Teams (ISTs) (ISTs are part of NHS Improving Quality (NHSIQ), and a joint intelligence group represented by NHS England, Department of Health (DH) NHS Trust Development Authority (NHS TDA) and Monitor). 4. Recovery and Improvement plans have been produced by all organisations with an A&E unit (not just those currently failing) to ensure whole systems sustainability and all year round delivery with a particular focus on winter. 5. £250m non-recurrent winter funding confirmed for targeted use for 2013/14 (same for 2014/15). 6. NHS 111 programme board in place.	1. Chief Operating Officer reports to the NHS Operations Executive and to the Board on current performance and related issues. 2.Weekly A&E data published on NHS England website.	1. Weekly delivery stock take meetings with Secretary of State (SofS). 2. NHS TDA, Monitor and Association of Directors of Adult Social services represented in regional and national tripartite groups providing assurance functions.	4	4	R	⇨	1. External stakeholders from Royal Colleges etc, currently being sought to inform this work. 2. Currently working to identify external stakeholders.	1. 30/09/2013 2. 30/09/2013	4	3	AR
Chief Nursing Officer Supported by National Director: Policy, Medical Director and Chief Operating Officer	**5**	**Clarity of roles** There is a risk that a lack of clarity in an immature system, whether between NHS England and partner organisations or within NHS England itself results in less ability to effectively commission services that are safe, clinically effective and provide the appropriate levels of quality of care.	✓					✓						5	3	R	1. Clear definitions of what high quality care looks like for particular pathways or patient groups and what commissioners can do to commission it, by: • Developing a framework of support for commissioners as to how they can practically discharge their roles and responsibilities around quality at all points of the commissioning cycle, in co-production with the Quality Working Group of the NHS Commissioning Assembly, to include how they can work with regulators and other bodies locally. • National leadership for quality across the system, with NHS England as an equal voice on behalf of commissioners - through the National Quality Board, brings together CQC, Monitor, NHS TDA, NICE, PHE, HEE, etc to provide oversight and leadership for quality. • NHS England involvement in local safeguarding boards. • Work with the Care Quality Commission (CQC), professional regulatory bodies and other national partners.	1. Chief Nursing Officer reports to the Board on Domain 5. 2. Reporting on adverse and near events.	1. Local safeguarding boards (tbc). 2. CQC, professional regulatory bodies and other national partners including National Advisory Group on the Safety of Patients in England.	4	2	A	⇩	1. Establish patient safety board. 2. To deliver on the outcomes and recommendations of the Keogh Review in partnership between NHS England, NHS Trust Development Authority, Monitor and Care Quality Commission.	1. 30/09/2013	4	2	A
Chief Operating Officer	**6**	**Primary Care Services (Formally Family Health Services):** There is a risk that the necessary reduction in management costs for this service could result in operational difficulties which could damage NHS England's relationships with GPs.	✓					✓			✓		✓	4	4	R	1. Project plan with centrally funded National Project Team. 2. Area teams actively engaged. 3. Mechanism in place to handle operational issues as they arise. To include publication of national procedures / policies and potential flexing of existing private sector contracts. 4. Plans from Area Teams organised via regional offices and then via National Project Team.	1. Programme board in place with regular reporting to the executive team meeting (ETM). 2. Board will be updated on the 17 July 2013 and a paper with proposals will be taken to the Board on the 13 September 2013. 3. Risks associated with lack of capacity identified and mitigated via business cases, reporting to Procurement Controls Committee. 4. Included in the internal audit plan for review.	1. Reviews of plan by Primary Care Services (PCS) Programme Board; service specification to be cleared through Clinical Priorities Assurance Group. 2. Engagement plan with contractor representative groups. 3. Engagement plan with unions on workforce transition plan; involvement of and advice sought from NHS Business Services Authority (NHS BSA) re -procurement.	4	4	R	⇨	1. Senior Responsible Officer (SRO) will take governance arrangements to appropriate approval meetings. 2. Funds exist to meet financial demands of project but arrangements to be clarified with Finance on carry-over if spending is delayed into early 2014/15. 3. Communications plan being developed. 4. Appointment of project resource. 5. Project governance arrangements in place although still to be formally ratified. Project arrangements will need to be in place for October 2013 to 31 March 2014. 6. Risk plans being developed for each work stream area.	1. 30/09/2013 2. 31/03/2014 3. 31/03/2014 4. 01/10/2013 5. 30/09/2013 6. 30/09/2013	4	3	AR

Risk Owner	Risk Ref	Potential Risk Description	Business Plan Score Card Priority												Initial Risk Score (see note 1)			Mitigating Actions in Place	Internal Assurance	External Assurance	Current Residual Risk Score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion Date for Actions	Anticipated Risk Score Following Mitigation (see note 3)		
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		Should be high-level potential risks that are unlikely to be fully resolved and require on-going control															*Systems and processes that are in place and operating that mitigate this risk*	*Internal evidence that this risk is being effectively managed (e.g. Board reporting, subcommittee and internal audit committee reviews)*	*External evidence that this risk is being effectively managed (e.g. planned or received external audit reviews)*					*Additional actions required to mitigate this risk further*	*For each further mitigating actions a completion date must be provided*			
Chief Operating Officer	**7**	**NHS 111 Services:** There is a risk that NHS 111 services cannot be rolled out across England safely in line with original timetable and that already live services could be compromised due to provider failure.					✓		✓		✓			4	4	R	1. Strategic review of NHS 111 Services. 2. Operations Directorate working with CCGs to secure clear plans for delivery of service. 3. CCG assurance framework in place. 4. Close monitoring of NHS direct capacity and sustainability with NHS Trust Development Authority (NHS TDA). 5. Support for CCG's to secure alternative providers where necessary. 6. Operational decision to delay rollout in two sites.	1. Established Programme Oversight Group. 2. Established weekly Operational Group. 3. Established NHS Direct 111 Service. 4. Liaison and Negotiating group with CCGs. 5. Checkpoint process in place for service roll out.	1. Deloitte report into NHS Direct contracted services. 2. Assurance of higher risk recovery plans undertaken by Deloitte.	4	4	R	⇨	1. Business case to be developed for external assurance of mobilisation plans as services are procured.	1. 31/10/2013	4	3	AR
Chief Operating Officer Supported by: National Director: Commissioning Development and Chief Financial Officer	**8**	**CCG Development:** There is a risk that some CCGs do not reach the maturity level to deliver the strategic plans required to improve patient care and ensure a clinically and financially sustainable health system.	✓		✓	✓	✓	✓	✓	✓	✓			✓	4	4	R	1. CCG development programme in place. 2. CCG Assurance Framework in place. 3. Support offered by NHS England and Commissioning Support Units (CSU). 4. The four regions are having on-going conversations with Area Teams and CCGs around remaining conditions and concerns, working towards the removal of any remaining conditions of authorisation. Reviews of conditions and directions of authorisation are also reviewed on a formal basis through the quarterly checkpoint of annual assurance, and considered by CCG Authorisation and Assurance Committee (on-going, first committee on 8 Oct 2013). 5. Commissioning development programmes (including area teams) to be aligned across the system.	1. Board reporting on CCG development programme. 2. Board reporting on CCG assurance framework. 3. Authorisation Committee review of conditions. 4. Included in the internal audit plan for review.		4	4	R	⇨	1. Engagement project plan is in place and being rolled out to ensure final assurance framework is co-produced with CCGs, prior to final publication in the autumn. 2. The four regions are having ongoing conversations with Area Teams and CCGs around remaining conditions and concerns, working towards the removal of any remaining conditions of authorisation. Reviews of conditions and directions of authorisation are also reviewed on a formal basis through the quarterly checkpoint of annual assurance.	1. 31/11/2013 2. Ongoing	4	2	A
National Director: Commissioning Development Supported by: Chief Operating Officer and National Medical Director	**9**	**Primary Care:** There is a risk that due to demographic pressures and a tight financial environment, general practice will face increasing challenges in securing continuous quality improvement leading to an impact on reducing the variations in quality and access.	✓		✓	✓	✓	✓	✓	✓	✓				4	4	R	1. Development of strategic framework for commissioning of primary care services. 2. Development of GP contract. 3. Primary medical services assurance framework. 4. NHS Commissioning Assembly primary care working group to develop and test ideas. 5. Successful launch of 'A Call to Action' for general practice.	1. Primary Care Strategic Framework Oversight Group. 2. National Primary Medical Services Assurance and Quality Improvement Steering Group. 3. Board approval for negotiating remit for 2014/15 GP contract.	1. CQC assessment of general practices.	4	2	A	⇩	1. Development by area teams, CCG's and health and well-being boards of local strategic plans for primary care improvement as part of the 2014/15 planning round. 2. Support for CCG's in providing local clinical leadership for quality improvement in general practice.	1. 31/03/2014 2. 31/03/2014	4	2	A
National Director: Policy Supported by: National Director: Commissioning Development	**10**	**Health Inequalities:** There is a risk that immature partnerships, lack of good data and a poor evidence base, impair our ability to reduce inequalities in outcomes across the 5 domains.								✓	✓			4	4	R	1. NHS Equality and Diversity Council (EDC). 2. Equality Delivery System (EDS). 3. Partnership working with key stakeholders. 4. Equality and Diversity Group. 5. Resource allocation. 6. Primary care commissioning. 7. GP contracts and incentive review aligned to reducing inequalities.	1. Board task and finish group. 2. Equalities policy. 3. Included in the internal audit plan for review.	1. Department of Health (DH) assessment of NHS England's performance against duty to reduce health inequalities and to integrate services where reduces health inequalities. 2. Her Majesty's Treasury (HMT) reporting against Public Accounts Committee (PAC's) outstanding recommendations on Health Inequalities.	4	3	AR	⇩	1. Development and publication of an Equality and Health Inequalities Strategy. 2. Co-production with clinical domain leads to identify data sets and develop intelligence to underpin their work streams. 3. An analysis schedule of the 5 domains developed across the analytical team and the Equality and Health Inequalities team to identify priorities for intelligence and current gaps in data sets. 4. Cross agency scoping and development of data sets and intelligence to underpin the Health Inequalities strategy with Public Health England (PHE), Department of Health (DH) and the Office of National Statistics. 5. Use of summary data across individual characteristics until there is access to data that allows combination of the different characteristic to uncover interchanges and provide more accurate intelligence. 6. Work with Domain leads to scope gaps in health inequalities intelligence; work with partners, including Health Social care Information Centre (HSCIC) on data collections, to develop evidence base for all Domains.	1. 31/10/2013 2. 13/09/2013 3. 13/09/2013 4. 31/03/2014 5. 31/03/2014 6. 31/03/2014	4	2	A
National Director: Patients and information Supported by: National Director: Commissioning Development	**11**	**Information Governance:** There is a risk that the changes to the Information Governance (IG) environment impact on the ability of commissioners to operate effectively, leading to reduced ability to have a significant impact on improving patient outcomes. Specifically: • Risks to the commissioning system: ability to target and commission improved services for patients and ensure value for money from providers; • Risk to commissioning support services: potential to destabilise CSUs and their ability to meet CCG customer expectations and be financially sustainable; • Reputational risks for NHS England: the ability for NHS England to maintain business as usual in the first year of operation.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	4	5	R	Establishment of a Programme Board (including a programme manager to ensure the completion of key programme documentation, controls and plans) to oversee the full range of activities required to ensure a successful transition to new IG environment including: • identify the full implications of the new information governance environment for commissioning and commissioning support tools, ensure that they are effectively communicated to and understood by commissioners, and that any changes in practice are implemented in a way that is consistent with the law; • ensure robust management of the risks to the overall commissioning system and in the processes involved in handling confidential data and using it to support commissioning practice and care; ensure a smooth transition from current practice to how it needs to work in the future; • oversee the process of separation of the Data Management Information Centre (DMICs) from Commissioning Support Units (CSUs), and their formal migration to the Health and Social Care Information Centre (HSCIC), addressing all the technical, operational, funding, HR and leadership issues. • ensure that the emerging effects on CSUs, including the implications for their future operating model and sustainability, are effectively addressed; • continue to manage the issue of s251 support for commissioning during the transition period.	1. Update reports from joint Senior Responsible Officers (SROs) to the Executive Management Team (ETM). 2. Included in the internal audit plan for review (August 2013).		4	3	AR	⇩	1. Implementation of an Internal Audit action plan, to be agreed following the internal audit of the IG Programme (August 2013).	1. 31/03/2014	3	2	A
Chief Nursing Officer Supported by: Chief Operating Officer	**12**	**Health Visitors:** There is a risk that an inability to recruit and train sufficient health visitors results in insufficient numbers to meet the target.	✓	✓				✓	✓					4	4	R	This is a particular issue in London and Kent, Surrey, Sussex (KSS) where recovery plans include: 1.Workstream around rebranding and marketing of Health visiting (London to spearhead). 2.Work with Health Environment Inspectorate Framework (HEIs) to delay course start to allow sufficient places.	1. Chief nursing officer reports to the Board. 2. Included in the internal audit plan for review.	1. Development of regular communication pathway with Community Practitioners and Health Visitors Association (CPHVA), Department of Health (DH), NHS England and Health Education England (HEE). 2. Refreshed Joint Programme Board (yet to be confirmed).	3	3	A	⇩	1. Revise and assess communication pathways for effectiveness. 2. Assess effectiveness of interventions in lead up to next recruitment cohort. 3. Developing Band 5 nurse readiness for health visiting, ahead of upcoming training cohorts (Kent). 4. Ensure guaranteed placements for trained health visitors. 5. Development of Health Visiting Transformation boards in London & KSS.	1. 31/10/2013 2. 31/10/2013 3. 31/10/2013 4. 31/10/2013 5. 31/10/2013	3	3	A

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		Should be high-level potential risks that are unlikely to be fully resolved and require on-going control																*Systems and processes that are in place and operating that mitigate this risk*	*Internal evidence that this risk is being effectively managed (e.g. Board reporting, subcommittee and internal audit committee reviews)*	*External evidence that this risk is being effectively managed (e.g. planned or received external audit reviews)*					*Additional actions required to mitigate this risk further*	*For each further mitigating actions a completion date must be provided*			
Chief Nursing Officer	**13**	**Compassion in Practice:** There is a risk that inadequate engagement with health professionals and / or lack of clarity of roles, responsibilities, and processes of national and local partners means that NHS England does not deliver Compassion in Practice, leading to sub-optimal outcomes and dissatisfied patients.	✓	✓	✓	✓	✓	✓	✓	✓	✓			4	3	AR	1. Compassion in Practice implementation plans overseen by NHS England and Federation of Nurse Leaders. 2. Chief Nursing Officer supporting the delivery of local and regional actions. 3. There is excellent engagement with national bodies, regulators and key stakeholders. 4. Continuous networking and engagement with stakeholder at local and national level. 5. Ensure NHS England's response to the Francis report is consistent with Compassion in Practice implementation plans, achieved in April 2013. 6. Launch of 6CsLive Communication Hub.	1. Chief Nursing Officer reports to the Board. 2. Progress reports against implementation plans. 3.Internally engagement and business planning to ensure processes are developed to support the delivery of Compassion in Practice.	1. Friends and Family Test. 2. Feedback from national bodies, regulators and key stakeholders. 3. Care Quality Commission (CQC) will report on the delivery of Compassion in Practice implementation plans when inspecting Trusts.	4	2	A	⇩	1. Quarterly review, of progress against the implementation plan. 2. Developing measures for success in quality of care in patient experience.	1. 30/09/2013 2. 30/09/2013	4	2	A
National Director: Commissioning Development Supported by Chief Financial Officer	**14**	**Commissioning support services:** There is a risk that NHS England fails to create the conditions whereby CSUs and other providers of commissioning support can provide high quality support to CCGs and NHS England commissioners in a way which enables transformation to take place at scale and takes account of difficult financial conditions.	✓		✓	✓	✓	✓	✓	✓				3	4	AR	1. Commissioning support services (CSS) transition programme. 2. Active development of the Commissioning Support Market - via Launch of the CSS Market Development Strategy 'Towards Commissioning Excellence' on 12/06/13. 3. Development programme for CSUs to ensure they continue to offer high quality & responsive services to CCGs & thrive within the future market.	1. Board reporting on CSU transition programme. 2.On-going Assurance regime through Monthly CSU Dashboard that monitors key performance and financial indicators 3. Specific Committee established to oversee assurance & development of CSUs & approach to market development. 4.Key Risks reported to the Board via both the committee & standard Board Programme Management Office (PMO) procedures. 5. Included in internal audit plan for review.	1. There will be on-going independent assessment of CSU financial viability 2. CSUs will be subject to NHS England's audit arrangements.	3	3	A	⇩	1. A programme of on-going development for CSUs, including a leadership programme is being implemented with the Leadership Academy to support CSUs in shaping their strategic direction, commerciality, bidding ability, Organisational Development and resilience. 2. An assurance regime is also in place to ensure the on-going financial viability of CSUs and that they are continuing to deliver excellent and efficient services that their customers value. 3. Clarity about where and how transition resources are sourced.	1. 31/03/2016 2. 31/03/2016 3. 31/03/2014	3	3	A
National Director: Policy Supported by: National Medical Director	**15**	**Transformation of Congenital Heart Services**: There is a risk that following the judicial review and Independent Reconfiguration Panel (IRP) reports on the 'safe and sustainable review', motivation and momentum for changes to congenital heart services is reduced and sustainability of good outcomes is endangered.	✓		✓			✓	✓	✓	✓			4	3	AR	1. Stakeholder engagement - maximum openness, working with and through e.g. National Voices, Involve, and Centre for Public Scrutiny; fortnightly blog on NHS England website for patient and public information. 2. Design a process which deliberately "front loads" the difficult issues to lessen risk of appeals and objections at the end of the process. 3. Commitment to a 12 month deadline for agreeing change.	1. 18 July 2013 Board to consider proposed approach, which will inform response to the Secretary of State (asked for 31 July 2013 update). 2. Board Task & Finish group, chaired by Sir Malcolm Grant, to meet regularly.	1. Governance model will include external input (possibly some international expertise, to avoid perceived parochialism).	4	2	A	⇩	1. Early meeting with National Voices etc, facilitated by Patients and Information, as precursor to meeting patient and parent charities. 2. Ongoing discussion with Communications to ensure appropriate support. 3. Make robust links to NHS England strategy process and to other significant workstreams e.g. on overall commissioning of specialised services and reconfiguration.	1. 01/06/2014 2. 01/06/2014 3. 01/06/2014	4	2	A
National Director: Patients and information	**16**	**World Class Customer Service:** There is a risk that NHS England are unable to persuade the clinical community of the benefits of sharing information. This will lead to the Health and Social Care Information centre not being able to deliver its objectives; on-going confusion across the system about the "dual governance" model that is operating; and NHS England failing to meet its commitments to make healthcare information transparent. It will lead to low participation of the public and patients in health and care.	✓							✓	✓			4	3	AR	1. Engagement with clinical leadership via Informatics Services Commissioning Group (ISCG) Clinical Reference group, to ensure the transparency and participation agenda receives appropriate levels of clinical input. 2. Established working relationship with the Health Information Centre through delivery of a Partnership Working Agreement which will set out a framework for joint working. 3. Robust work programme to address IG challenges, including provision of guidance to commissioners and stakeholders on how to overcome hurdles. . 4. The work of the Informatics Services Commissioning Group to help oversee delivery of the vision for improving services and delivery of benefits through transparency and patient participation. 5. Partnership working with the Healthcare Quality Improvement Partnership (HQIP) to help oversee the vision for data transparency through the delivery of publication of consultant data. 6. Use of the Standard Contract to require providers to publish information. Work on-going to consult on requirements.	1. Published consultant level quality and outcomes performance information for 10 key specialties. 2. Outputs from the Integrated intelligence tool (IIT). 3. Included in internal audit plan for review.	1. Healthcare Quality Improvements Partnerships (HQIP) published activity, clinical quality measures, and survival rates from national clinical audits.	4	3	AR	⇨	None identified.		4	2	A
National Director: Patients and information	**17**	**Patient and Public participation:** There is a risk that commissioners do not give adequate priority to patient and public engagement, leading to NHS England failing to meet its statutory obligation to engage patients and the public in the design and commissioning of health and care services.	✓							✓	✓			4	3	AR	1. Direct commissioning patient and public involvement has been designed into the system (formal requirement). 2. For CCGs, patient and public involvement is integral to the assurance programme. 3. Friends and Family Test roll out underway. Acute inpatient and A&E services went live in April. 4. NHS England implementing accelerator projects to support CCGs with public participation (on-going).	1. Board reporting on NHS England's direct commissioning. 2. Board reporting on the CCG assurance programme. 3. Board reporting on patient and public participation activity on the Integrated Customer Service Platform. 4. Board reporting on implementation of Friends and Family Test roll out plans.	None identified.	4	3	AR	⇨	1. Launch the Health and Social Care Digital Service (HSDP) and the Insight Dashboard as vehicles to drive and enhance public participation. 2. Maternity forecasted to go live in October. 3. Civil Society Assembly to be held in late 2013, which will operate as a vehicle and lever for ensuring public participation.	1. 01/11/2013 2. 31/10/2013 3. 31/12/2013	4	2	A
Chief Operating Officer	**18**	**Emergency Preparedness, Resilience and Response (EPRR)** There is a risk that given the new environment and changed personnel, exercises do not adequately test the incident response arrangements within NHS organisations leading to the system being unable to respond.		✓	✓		✓		✓					3	3	A	1. Agree the EPRR Training & Exercising Programme for 2013/14. 2. Implement the EPRR Annual "Safe System" Assurance to assure that NHS organisations' incident response plans are in place and that organisational reporting/response arrangements are aligned to them. 3. Maintain robust and constructive communication links with the four NHS England Regional EPRR Leads in relation to exercise scheduling and completion. 4. The London Regional Area Team is working with the Corporate Team to produce and deliver this product.	1.Quarterly updates to the EPRR partnership group. 2. Monthly reporting to the Department of Health (DH), Public Health England (PHE) and NHS England Training and Exercise Group who review all training and exercises Quarterly reporting on patient contact / complaints by end of July 2013. 3. Monthly meetings with Regional EPRR Leads.	1. Following each of the exercises (commissioned and paid for by DH) written reports to the DH, PHE and NHS England group.	3	3	A	⇨	1. Other exercises i.e. EMERGO exercises and other regional and Cross Government exercises such as Home Office led exercises; Cabinet Office exercises (Tier 1 and Tier 2). 2. Regular engagement with PHE, DH and Cabinet Office policy to understand where they are with guidance and ensure any publications are aligned and complementary where possible.	1. Ongoing 2. Ongoing	2	2	AG
National Director: Medical	**26**	**Embedding Outcomes:** There is a risk that the five clinical domains are not fully embedded in the strategic programmes due to an insufficient focus on improving quality and outcomes for patients, leading to a failure to optimise impact on improving outcomes as set out in the NHS business plan objectives.			✓				✓					4	3	AR	1. Strategic programmes are developed to address improving outcomes and deliver through supporting commissioners to optimise their functions and using other tools, levers and mechanisms available and delivered through delivery partners e.g. NHS Improving Quality (NHSIQ). 2. Comms and engagement plan developed to ensure maximum coverage, buy-in and spread internally and externally. 3. Sufficiently senior representation from domain teams on all matrix groups across to ensure input and influence.	1. Outcomes domains programme board governance arrangements in place; clinical directorates reporting and assurance system includes delivery and benefits monitoring and return on investment tracking.	1. Analytical Team and information centre monitoring of outcomes indicators. 2. ITEG steering group and Monitoring of international comparators. 3. Programme boards for underpinning programs will feature members from across the system and patients where appropriate.	4	2	A	⇩	1. Domain programmes developed and plans put in place for delivery. 2. NHS Improving Quality engaged to join up delivery of domain programmes and improvement programmes managed by NHS Improving Quality.	1. 01/10/2013 2. 01/10/2013	3	2	A

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		Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	1 - Satisfied patients	2 - Motivated, positive NHS staff	3 - Domain 1, preventing people	4 - Domain 2, enhancing quality of	5 - Domain 3, Helping people recover from	6 - Domain 4, Positive experience of care	7 - Domain 5, Safe environment &	8 - Promoting equality and reducing	9 - NHS constitution rights and pledges	10 - Becoming an excellent organisation	11. High quality financial management	Impact	Likelihood	RAG Status	*Systems and processes that are in place and operating that mitigate this risk*	*Internal evidence that this risk is being effectively managed (e.g. Board reporting, subcommittee and internal audit committee reviews)*	*External evidence that this risk is being effectively managed (e.g. planned or received external audit reviews)*	Impact	Likelihood	RAG Status		*Additional actions required to mitigate this risk further*	*For each further mitigating actions a completion date must be provided*	Impact	Likelihood	RAG Status
National Director: Commissioning Development Supported by: All	**27**	**Development of Commissioning** There is a risk that in an immature system, the development of capability of the commissioners is not sufficient to assure the quality of service or drive continuous quality improvement in services they commission, leading to the right outcomes not being secured. This is particularly important with regard to all three aspects of quality.	✓		✓				✓			✓		4	3	**AR**	1. Clear definitions of what high quality care looks like for particular pathways or patient groups and what commissioners can do to commission it, by: • developing tools and resources which support the implementation of quality standards, such as service specifications which can be inserted into contracts • developing a framework of support for commissioners as to how they can practically discharge their roles and responsibilities around quality at all points of the commissioning cycle, in co-production with the Quality Working Group of the NHS Commissioning Assembly, to include how they can work with regulators and other bodies locally • catalysing a movement towards a seven-day service offer in the NHS to remove barriers for commissioners in commissioning 7 day services from providers. 2. Improving the availability of measures and data on quality to support transparency of quality and help commissioners drive improvement by: • National Clinical Audit and Patient Outcomes Programme, ensures clinical audits cover the services which account for the majority of NHS activity. • Linking GP and hospital data to be able to understand the quality of care and outcomes for individuals throughout their pathway of care, through Care.data 3. NHS England uses the following levers to encourage, incentivise and enable commissioners to drive improvement, e.g. Quality Premium, the Planning Guidance for 2014/14, the CCG Outcomes Indicator Set, the tariff and best practice tariffs, the Quality and Outcomes Framework. 4. National leadership for quality across the system, with NHS England as an equal voice on behalf of commissioners - through the National Quality Board, brings together CQC, Monitor, NHS TDA, NICE, PHE, HEE, etc to provide oversight and leadership for quality. 5. The NHS architecture enables local health economies to share information on quality, triangulate intelligence, spot problems at an early stage and take coordinated actions - through Quality Surveillance Groups and Risk Summits.	1. CCG Leaders will steer work through the Quality Working Group of the Commissioning Assembly.	1. Work will report into Quality and Clinical Risk Committee of NHS England Board. 2. National Quality Board will provide oversight from across the system.	4	2	**A**	⇩	1. Working with NICE in developing their library of Quality Standards. 2.Publishing activity and outcomes data from national clinical audits at consultant-level for the first time for 10 specialties.	1. 01/01/2014 2. 01/01/2014	3	2	**A**
National Director: Medical	**28**	**Innovation and Research** There is a risk that we do not achieve the potential service improvement and financial benefits (including appropriate return from the investment of resource) in innovation and research if innovation and research practices are not mainstreamed into core activities. This would lead to poorer outcomes for patients and a financially unstable health system.			✓				✓				✓	3	4	**AR**	1. Support and assurance to CCGs who have a legal duty to promote innovation and research. 2. Develop research strategy and prioritisation process and disseminate across organisation. 3. Implementation of portfolio of innovation programmes underway.	1. Clinical directorates reporting and assurance system includes delivery and benefits monitoring and return on investment tracking; Clear clinical leadership in development of research strategy.	1. Academic programme for Evaluation of Innovation, Health and Wealth is being developed.	3	2	**A**	⇩	1. Full engagement on development of research strategy to take place during 2013/14. 2. Roll-out of innovation programmes throughout 2013/14.	1. 31/03/2014 2. 31/03/2014	2	2	**AG**
Chief Operating Officer	**31**	**Activity Control** There is a risk that lack of robust activity data will impede NHS England's ability to challenge and confirm providers of specialised commissioning, oversee and track CCG progress on activity and finance and agree baselines for future planning.												4	4	**R**	1. Work is underway, through the IG Programme (see risk 11), to provide solutions to the new IG arrangements that are impeding the access of area teams to hospital activity data, and their ability to validate invoices (on-going action through Summer and Autumn 2013). 2. the complexity of determining what is commissioned by CCGs versus what is directly commissioned by NHS England is currently being worked through. The re-commissioning of the Integrated Reporting tool via HSCIC will assist with this work. Part of the Review is to scope the extent of the problem to get a better sense of the scale of the issue. 3. A report has been delivered to identify the problems and recommend solutions.	1. Current review being undertaken via the Activity Information Project.	None identified.	4	4	**R**	⇨	None identified.		3	2	**A**
CREATING AN EXCELLENT ORGANISATION																												
Chief Financial Officer Supported by: National Director: Policy	**19**	**Transition - Transfer of Assets and Liabilities:** There is a risk that NHS England will face significant unforeseen liabilities and impairment of assets resulting from the significant structural changes leading to a failure to achieve financial performance targets for 2013/14, an inability to plan effectively for 2014/15, and problems with completing satisfactory accounts.											✓	4	4	**R**	1. Update reports by Chief Financial Officer to the Finance and Investment Committee. 2. Financial reporting to ETM (Executive Team Meeting) and the Board. 3. A two stage process has been agreed for asset and liability transfer: • "Assurance Process" - ensure that asset and liabilities transferring to NHS England are in accordance with the transfer scheme requirements and agree to the relevant accounting records for 2012/13. •. Verify the true underlying assets and liabilities concerned through due diligence process and assess the results in the context of 2012/13 final position and risk sharing agreement.	1. External audit review of Opening Balances. 2. Included in internal audit plan for review.	1. External audit review of Opening Balances.	4	3	**AR**	⇩	1. Develop and implement Transfer Order work streams. 2. Continue engagement with NHS Property Company. 3. Agree Internal audit plan and scope of reviews. 4. Agree external audit plan and scope of work. 5. Develop and agree detailed plan for reviewing transfer schemes and the workings to support transfer of assets and liabilities. 6. Develop the accounting environment for legacy items and resource accordingly. 7. Develop risk sharing agreement with Department of Health (DH) and key stakeholders to cover the financial impact of any legacy items. 8. For assets and liabilities relating to clinical contracts, develop a consolidated approach to transfer to mitigate the risk associated with disaggregation. 9. Develop plan for on-going management of assets and liabilities transferred.	1. 31/03/2014 2. 31/03/2014 3. 31/03/2014 4. 31/03/2014 5. 31/03/2014 6. 31/03/2014 7. 31/03/2014 8. 31/03/2014 9. 31/03/2014	4	2	**A**
National Director: HR	**21**	**Human Resources:** There is a risk that NHS England is unable to attract and retain suitable candidates of the required capability and diversity to fill key roles, including at the very top of the organisation, leading to a failure to deliver business objectives.								✓		✓		4	3	**AR**	1. Regular analysis and reporting of workforce data on turnover, vacancies and diversity. 2. Exit interview process. 3. Staff barometer.	1. Integrated performance report to Board to include qualitative and quantitative workforce data. 2. Included in the internal audit plan for review. 3. Remuneration and Terms of Service Committee business.	1. 360 degree feedback from stakeholders and partners.	4	3	**AR**	⇨	1. Develop and implement a succession planning strategy for NHS England. 2. Develop and implement an inclusion strategy for NHS England. 3. Develop an attraction strategy linked to brand.	1. 31/03/2014 2. 31/03/2014 3. 31/03/2014	4	2	**A**

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		Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	1 - Satisfied patients	2 - Motivated, positive NHS staff	3 - Domain 1, preventing people	4 - Domain 2, enhancing quality of	5 - Domain 3, Helping people recover from	6 - Domain 4, Positive experience of care	7 - Domain 5, Safe environment &	8 - Promoting equality and reducing	9 - NHS constitution rights and pledges	10 - Becoming an excellent organisation	11. High quality financial management	Impact	Likelihood	RAG Status	*Systems and processes that are in place and operating that mitigate this risk*	*Internal evidence that this risk is being effectively managed (e.g. Board reporting, subcommittee and internal audit committee reviews)*	*External evidence that this risk is being effectively managed (e.g. planned or received external audit reviews)*	Impact	Likelihood	RAG Status		*Additional actions required to mitigate this risk further*	*For each further mitigating actions a completion date must be provided*	Impact	Likelihood	RAG Status
Chief Financial Officer Support by: National Director: Policy	**22**	**Procurement:** There is a risk that NHS England is restricted in the way it operates due to Cabinet Office or other government procurement controls leading to failure to deliver business objectives– or that the complexity of the various government procurement regimes leads to them being breached – with consequential reputational damage in either case.		✓								✓	✓	✓	4	4	R	1. Dialogue with Department of Health (DH) sponsor to ensure clarity and appropriateness of procurement rules and delegations. 2. Business processes within integrated accounting system to ensure compliance with standing orders and standing financial instructions incorporating government procurement controls. 3. Delegated authority vested in Procurement Controls Committee meeting on a weekly basis. 4. Revised draft regulations have now been received from DH.	1. Procurement exception reporting to Audit Committee. 2. Continuous monitoring by Executive Team and Board of business plan delivery.	1. Operation of procurement regime overseen by DH sponsor team. 2. Procurement controls included as a specific workstream within Internal Audit programme.	4	3	AR	⇩	None identified.		4	3	AR
National Director: Policy	**23**	**Dealing with Customer Contacts**: There is a risk that the transition arrangements for dealing with complaints and customer contacts fail to reflect NHS England's values and commitments to a public and patient voice, leading to low public and patients satisfaction in NHS England.	✓								✓	✓		4	4	R	1. Quarterly reporting on patient satisfaction with customer contact arrangements by end of July 2013. 2. Quarterly reporting on patient contact / complaints by end of July 2013. 3. New process, and additional capacity in place to deal with whole of complaints at local level. 4. Additional capacity in place to deal with correspondence.	1. Daily and weekly report shared with Commissioning Support Units (CSUs) and Area Teams. 2. Regular reporting to executive team. 3. Daily conference call with the CSUs commissioned by Area Team to resolve complaints. 4. Weekly meetings with Area Team Directors. 5. Service Teams from directorates engaged in matrix group, first meeting end of July 2013. 6. Report to every Board meeting. 7. Included in internal audit plan for review.	1. Engagement plan with external stakeholder groups such as the Ombudsman and Healthwatch to keep arrangement under review over next six months.	4	3	AR	⇩	1. Further training and development for contact centre staff over next 1-3 months to improve the percentage of customer contacts resolved at first contact. 2. Quarterly reporting on patient contact / complaints to the November Board.	1. 30/09/2013 2. 08/11/2013	3	3	A
National Director: Policy	**24**	**Transition - ICT:** There is a risk that NHS England's corporate Information and Communications Technology (ICT) strategy implementation plan is delayed, particularly given the scale of the programme in an immature organisation and the newness of the ATOS offer, leading to an inability of regional and area teams to deliver the business plan, and work efficiently in an agile and flexible way.		✓								✓		4	3	AR	1. Programme board in place with weekly supplier delivery reports. 2. Weekly review of implementation plan, correct and re-align activities and focus where necessary, provision of weekly status and progress report to the National Director: Policy. 3. Additional helpline capacity in place (ATOS).	1. Customer representation on programme board. 2. Department of Health (DH) and other Arm's Length Bodies (ALBs) implementing Open Service knowledge and learning exchange taking place. 3. Deloitte will be involved in ICT audit, so this may add further independent review. 4. Included in internal audit plan for review.	1. Customer representation on programme board. 2. Department of Health (DH) and other Arm's Length Bodies (ALBs) implementing Open Service knowledge and learning exchange taking place. 3. Deloitte will be involved in ICT audit, so this may add further independent review.	3	3	A	⇩	1. As part of deployment method capture feedback and feed into the approach as an "after action review" stage. 2. Develop implementation feedback process, to continuously improve deployment approach and customer experience.	1. 31/10/2013 2. 31/10/2013	3	2	A
National Director: All National Directors	**25**	**Organisational Culture:** There is a risk that NHS England does not create the conditions where staff feel motivated to give their best, where lack of clarity around roles and responsibilities, shared goals, and their experience of NHS England as an employer is variable dependent upon work location, leading to demotivation, disengagement and poor levels of staff satisfaction, subsequent impact on productivity, and the potential loss of talent leading to capacity and capability challenges in delivering business objectives.		✓								✓		4	3	AR	1. Interim performance and development review process. 2. Regular staff barometer. 3. Leadership Forum. 4. Exit interviews. 5. Workforce data analysis- e.g. turnover, vacancy rate.	1. Integrated performance report to Board to include qualitative and quantitative workforce data. 2. Included in internal audit plan for review. 3. Remuneration and Terms of Service Committee business.	1. 360 degree feedback from stakeholders and partners.	4	3	AR	⇨	1. End state Personal Development Review (PDR) which will assess individuals' performance against organisation values. 2. Action planning for improvements in response to Staff Barometer results at both team and organisation level. 3. Target developmental interventions in areas where workforce information and staff experience data identify particular challenges.	1. 31/03/2014 2. 31/08/2013 3. 31/03/2014	2	2	AG
ALL Co-ordinating National Director: Policy	**30**	**Immature Systems and Processes:** There is a risk that immature systems and governance processes in NHS England could impede the delivery of a number of key objectives, leading to poorer outcomes for patients.			✓							✓		4	4	R	1. Executive Risk management Team established to monitor high level and key risks. 2.Regular Senior Management Team meetings established in all National Directorates to keep on top of tasks. 3. Internal 'hygiene group' established tackle internal issues. 4. Policy, Operations and Commissioning Development Directorates are working together on an internal governance and assurance framework for reconfigurations of directly commissioned services, and for joint collaborative decision making structures where schemes span both CCG and directly commissioned services.	1 Monitored through integrated performance reports which is discussed at Board. 2. Staff barometer results which are discussed at Executive Team Meeting. 3. Monthly leadership Forum. 4. Regional Directors attend monthly executive team meeting. 5. Monthly Operations Executive meetings.	None identified.	3	3	A	⇩	None identified.		2	2	AG
National Director: Policy	**32**	**External Partners - priorities and whole system approach:** There is a risk that lack of alignment between organisational visions and priorities could hinder the establishment of, and commitment to, a shared system-wide purpose, leading to a lack of progress in the health and social care agenda, for example regarding views on competition.			✓	✓	✓	✓	✓				✓	3	3	A	1. Arms Length Body chief executives meet regularly, as do directors of strategy and other professional leadership groups. 2. Partnership Agreements are in place between NHS England and key organisations. 3. Joint Executive and Board meetings take place to facilitate joint working and confirm shared priorities. 3. ALBs and other partners have signed up to, and are participating in the 'call to action' strategy process.	1. Partnership implications of specific policies or initiatives are reported to Board on a case-by-case basis.	1. The Board will receive structured feedback from partners on the extent to which they are satisfied with their engagement with NHS England.	3	2	A	⇩	1. To deliver on the outcomes and recommendations of the Keogh Review in partnership between NHS England, NHS Trust Development Authority, Monitor and Care Quality Commission.	1. Ongoing	3	2	A
National Director: Policy Supported by: Chief Financial Officer	**33**	**Capacity and Capability:** There is a risk that NHS England will not have the management capacity required to deliver on ambitious plans, both now and in the future, due to reductions in management resources, and additional priorities for action (which may be conflicting), leading to an impact on the ability to fulfil statutory obligations, deliver core business plan objectives and improvement in outcomes.	✓	✓	✓	✓	✓	✓	✓					4	3	AR	1. Tight budgetary control, overseen by Executive Team, with modest contingency available for pressures emerging during the year. 2. Regular review of resource alignment with business needs, resulting in budgetary and staffing adjustments where appropriate. 3. Regular monitoring of business plan delivery to ensure early identification of risks and corrective action. 4. Annual resource planning based on strategic priorities. 5. Meeting with DH and NHS England to discuss the issue of emerging action / priorities. 6. Bi-monthly meetings take place between the chairman and secretary of state.	1. Business Plan Deliverables reported at ETM and Board. 2. Ongoing meetings with DH to support and influence the Mandate refresh, and associated work priorities.	None identified.	4	3	AR	⇨	1. Board to receive a report of management cost savings.	1. 30/09/2013	3	2	A

Note 1 - Initial risk score	An assessment of the risk at the start, based upon the information available, prior to the consideration of any mitigating actions.
Note 2 - Current residual risk score	The most up-to-date score assessed by taking into account current information and consideration of the mitigating actions.

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Note 3 - Anticipated risk score following mitigation	An intended score to be achieved following the completion of all the mitigating actions.																											