

**BOARD PAPER - NHS ENGLAND**

**Title:** Board Assurance Framework (incorporating the organisation's strategic risks)

**Clearance:** National Director, Policy: Bill McCarthy

**Purpose of paper:**

- To update the Board on its Assurance Framework for NHS England, incorporating the strategic risks for the organisation.

**Key issues and recommendations:**

The Board Assurance Framework sets out a list of strategic risks, current mitigating actions and internal and external assurances. The Board Assurance Framework identifies further mitigating actions to be taken for each risk area.

**Actions required by Board Members:**

The Board is asked to:

- receive the BAF;
- accept the risks; and
- receive assurance that mitigating actions are in place.

## **Board Assurance Framework**

### **Background**

1. The Board Assurance Framework (BAF) forms part of the NHS England risk management strategy and policy and is the framework for identification and management of strategic risks; both risks internal to NHS England and those in the wider system in which NHS England has a role.
2. The BAF is reviewed on a monthly basis by the executive risk management group, who finalise the list of strategic risks, confirm actions being undertaken and check assurances.

### **The Board Assurance Framework 2013 / 14**

3. The executive risk management group has not met since the last Board meeting, on the 24 Jan 2014. However, work has been undertaken by correspondence to review the BAF by the group's members, resulting in an updated version. The updated BAF summary sheet is attached as annex A, with the full BAF attached as annex B.
4. The updated version shows a reduction of the scores for two risks, the urgent care demand risk (number 4) and the transition transfer of assets and liabilities risk (number 19). The urgent care demand risk score has reduced from a 4 to a 2 for likelihood, following the four hour A&E standard being achieved for quarter 3. The transition transfer of assets and liabilities risk has reduced in impact, after the agreement of an accounts direction for 2013/14.
5. The activity control risk (number 31) has increased from a 3 to a 4 for likelihood. Additional mitigating actions have been added to manage this risk, including discussion of the risk at the executive team meeting and area directors meeting.
6. New actions have been added to three of the risks to help mitigate them. The actions for the direct commissioning risk (number 3) relate to the implementation of an assurance framework, including the launch of operational guidance.
7. New actions added to the emergency preparedness, resilience and response risk (number 18) relate to learning lessons identified from regional exercise programmes and additional assurance via weekly status meetings with Public Health England and the Department of Health.
8. Finally, the new actions added to the NHS 111 service risk (number 7) cover the transfer of the service contracts from NHS Direct to new providers, the start of the development of a vision and business case for future service delivery and completion of a quality and safety review and on-going clinical governance arrangements. The addition of these actions has reduced the anticipated risk score to an amber/green from an amber score.

9. There have been a number of single mitigating actions which have either been completed or clarified, including two for the development of commissioning risk (number 27). The actions to work with the National Institute for Health and Care Excellence (NICE) to develop their library of quality standards, and the publication of outcomes data from national clinical audits at consultant level in ten specialities, have both been completed.
10. Further actions now completed include the publication of the 2014/15 strategic and operational planning guidance and support, an action for the strategy risk (number 1). Additionally, the actions associated with the dealing with customer contacts risk (number 23) to produce a 'learning from complaints strategy' and related action plan, and the undertaking of sampling of complaints to review the quality of responses, have been completed.

**Actions Required by Board Members:**

11. The Board is asked to:
  - receive the BAF;
  - accept the risks; and
  - receive assurance that mitigating actions are in place.

**Bill McCarthy**

**National Director: Policy**

**March 2014**

## NHS England Board Assurance Framework Summary as at 30 January 2014

Risk Ref	Potential Risk Description	Initial Risk Score			Current Residual Risk Score			Residual risk progress since last meeting	Anticipated Risk Score Following Mitigation		
		Impact	Likelihood	RAG Status	Impact	Likelihood	RAG Status		Impact	Likelihood	RAG Status
		<i>High-level potential risks that are unlikely to be fully resolved and require on-going control</i>									
1	<b>Strategy</b> - 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.	5	4	R	4	4	R	→	4	3	AR
2	<b>Financial Risk in Partner Organisations</b> - serious financial difficulties elsewhere in the health and social care sector leads to an adverse impact on commissioners.	4	4	R	4	3	AR	→	4	3	AR
3	<b>Direct Commissioning</b> - underdeveloped direct commissioning processes do not discharge specialised commissioning responsibilities effectively.	4	4	R	4	4	R	→	4	3	AR
4	<b>Urgent Care Demand</b> - increasing demand for urgent and emergency services leads to a threat to delivery of key operational standards.	4	4	R	4	2	A	↓	4	2	A
5	<b>Clarity of Roles</b> - lack of clarity of roles and responsibilities in national and local organisations results in NHS England not delivering the desired improvements in services that are safe, clinically effective and provide the appropriate levels of quality of care.	5	3	R	4	2	A	→	4	2	A
6	<b>Primary Care Services</b> - the necessary reduction in management costs for this service could result in operational difficulties.	4	4	R	4	4	R	→	4	3	AR
7	<b>NHS 111 Services</b> - NHS 111 services cannot be rolled out across England safely in line with the original timetable.	4	4	R	3	3	A	→	3	3	A
8	<b>CCG Development</b> - CCGs do not reach the maturity level to deliver the strategic plans required to improve patient care.	4	4	R	4	3	AR	→	4	2	A
9	<b>Primary Care</b> - general practice will face increasing challenges in securing continuous quality improvement.	4	4	R	4	2	A	→	4	2	A
10	<b>Health Inequalities</b> - immature partnerships, lack of good data and a poor evidence base, impair NHS England's ability to reduce inequalities in outcomes across the five domains.	4	4	R	4	3	AR	→	4	2	A
11	<b>Information Governance</b> - changes to the Information Governance environment impact on the ability of commissioners to operate effectively.	4	5	R	4	3	AR	→	3	2	A
12	<b>Health Visitors</b> - an inability to recruit and train sufficient health visitors results in insufficient numbers to meet the target.	4	4	R	3	3	A	→	3	3	A
13	<b>Compassion in Practice</b> - Inadequate engagement with health professionals and processes of national and local partners means that NHS England does not deliver Compassion in Practice.	4	3	AR	4	2	A	→	4	2	A
14	<b>Commissioning Support Services</b> - increasing financial pressures on CCGs leads to significant reduction in outsourcing of CSS and a shift to in-house provision, resulting in a loss of strategic transformational capability from the system, and potential liabilities.	3	4	AR	4	4	R	→	3	3	A
15	<b>Transformation of Congenital Heart Services</b> - motivation and momentum for changes to congenital heart services is reduced and sustainability of good outcomes is endangered.	4	3	AR	4	2	A	→	4	2	A
17	<b>Patient and Public Participation</b> - commissioners do not give adequate priority to patient and public engagement.	4	3	AR	4	3	AR	→	4	2	A
18	<b>Emergency Preparedness, Resilience and Response</b> - given the new environment and changed personnel, exercises do not adequately test the incident response arrangements within NHS organisations.	3	3	A	3	3	A	→	2	2	AG
19	<b>Transition - Transfer of Assets and Liabilities</b> - NHS England will face significant unforeseen liabilities and impairment of assets resulting from the significant structural changes.	4	4	R	3	3	A	↓	3	2	A
21	<b>Human Resources</b> - NHS England is unable to attract suitable candidates to fill key roles.	4	3	AR	4	3	AR	→	4	2	A
22	<b>Procurement</b> - NHS England is restricted in the way it operates due to government procurement controls.	4	4	R	4	3	AR	→	4	3	AR
23	<b>Dealing with Customer Contacts</b> - the transition arrangements for dealing with complaints and customer contacts fail to reflect NHS England's values.	4	4	R	4	3	AR	→	3	3	A
24	<b>Transition - ICT</b> - NHS England's Information and Communications Technology (ICT) strategy implementation plan is delayed.	4	3	AR	3	3	A	→	3	2	A
25	<b>Organisational Culture</b> - NHS England fails to create a culture where there is a shared sense of purpose, clarity about our values and behaviours and how we work together and with others.	4	3	AR	4	3	AR	→	2	2	AG
26	<b>Embedding Outcomes</b> - the five clinical domains are not fully embedded in the strategic programmes due to an insufficient focus on improving quality and outcomes for patients.	4	3	AR	4	2	A	→	3	2	A
27	<b>Development of Commissioning</b> - some CCGs do not progress beyond the safe threshold achieved in CCG authorisation.	4	3	AR	4	2	A	→	3	2	A
28	<b>Innovation and Research</b> - do not achieve the potential benefits or get return from the investment in innovation and research.	3	4	AR	3	2	A	→	2	2	AG
30	<b>Immature Systems and Processes</b> - immature systems and governance processes in NHS England impede the delivery of a number of key objectives.	4	4	R	3	3	A	→	2	2	AG
31	<b>Activity Control</b> - 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 agree baselines for future planning.	4	4	R	4	4	R	↑	4	3	AR
32	<b>External Partners - Priorities and Whole System Approach</b> - lack of alignment between organisational visions and priorities lead to a lack of progress in the health and social care agenda.	3	3	A	3	2	A	→	3	2	A
33	<b>Capacity and Capability</b> - NHS England will not have the management capacity required to deliver on ambitious plans, now and in the future, due to current and future planned reductions in management resources alongside additional priorities for action.	4	3	AR	4	3	AR	→	3	2	A
34	<b>Transparency and Information Sharing</b> - NHS England will not persuade the clinical community of the benefits of sharing information.	4	3	AR	4	3	AR	→	4	2	A
35	<b>System Governance Uncertainty</b> - the complex governance and lack of NHS England control over informatics expenditure will impact on the ability to deliver on NHS England's agenda.	4	3	AR	4	3	AR	→	4	2	A

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)			Residual risk progress since last meeting	Further Mitigating Actions	Completion Date for Actions	Anticipated Risk Score Following Mitigation (see note 3)					
			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	9 - NHS reducing health inequalities	10 - Becoming an excellent organisation	11 - High quality financial management	Impact	Likelihood	RAG Status				Impact	Likelihood	RAG Status				Impact	Likelihood	RAG Status			
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 CCGs. 5. NHS England with Monitor, the Trust Development Authority and the Local Government Association have aligned their planning timetables and have regular meetings about their planning approach. 6. 2014/15 refreshed Mandate published. 7. 2014/15 Strategic and Operational planning guidance has been published.	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. Publish 2014 refresh of NHS England Business Plan.	1. 31/03/2014	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 strategic planning process includes a process of triangulation of commissioner and provider plans with the NHS Trust Development Authority (NHS TDA) and Monitor. 3. Support package being developed as part of the strategic planning process with Monitor and the TDA for challenged health economies. 4. NHS England has agreed a set of principles under which financial support may be provided to challenged Trusts. 5. Local reconciliations between commissioners and providers and agreement of balances exercise undertaken to ensure that consistent assumptions are being used by all parties.	1. 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 major programme established to ensure appropriate activity information is available, overseen by the Operations Directorate which includes the timely and relevant information on activity trends being made available to enable corrective action to be taken especially in direct commissioning.	1. 31/12/2013	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 approved by the Board and published November 2013. 6. Regional Director leads identified for each aspect. 7. Commissioning Support Unit service level agreements in place with steering group. 8. Dedicated project team has been established through rapid mobilisation of resources and high profile attention by the Executive Team. 9. Initial baseline assessment was carried out for Q2 data and is being reviewed. 10. Operational Guidance for launch of first full assurance round (Q3) under development.	1. Board development session 17 July 2013. 2. The Board has approved a Direct Commissioning Committee with Non-Executive Directors identified. 3. Included in the internal audit plan for review. 4. 5 x service area groups set up, including pre-existing Specialised Commissioning oversight group. 5. Oversight takes place through the Assurance Oversight Group, originally oversaw CCG Assurance only.	None identified.	4	4	R	➔	1. Work underway to clarify roles and responsibilities/methodologies relating to acting on assurance findings: development plans, resources, line management activity.	1. 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 (NHS IQ), 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. A total of £400m of non-recurrent funding has been made available across the system (£250m in first tranche announced in September and £150m announced in November). £371m has gone to local systems to support delivery of the A&E standard, and is being spent across acute, primary, community, mental health and social services as agreed by local partners. £15m has gone to NHS 111, £14m to ambulance services and £7m to specialist services. The use of all money will be monitored. 6. NHS 111 programme board in place. 7. External stakeholders have been identified to inform this work. 8. Winter situation reporting monitoring running from 4 November to end February 2014.	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 (SoS). 2. NHS TDA, Monitor and Association of Directors of Adult Social Services represented in regional and national tripartite groups providing assurance functions.	4	2	A	⬇	None identified.				A
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. 2. The Patient Safety Board has now been established, renamed as the Patient Safety Expert Group to bring together experts in specific fields.	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. 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. 31/03/2014	4	2	A
Chief Operating Officer	6	Primary Care Services (formerly 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. 5. Senior Responsible Officer (SRO) has received approval of governance arrangements from appropriate approval forums. 6. Project Governance arrangements were formally ratified on 3/10/13. 7. Risk plans are in place with regular updating. 8. Recruitment of Programme Director.	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. Financial Arrangements still to be clarified should spending be delayed and funding need to be carried over to 2014/15. Review of funds to take place March 2013. 2. Communications plan under development. 3. The direct commissioning sub-committee will act as the approving committee for business cases and other programme documentation. The sub-committee comprises of senior level staff and non-executive directors.	1. 31/03/2014 2. 31/03/2014 3. 31/01/2014	4	3	AR
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. Operational decision to delay rollout in two sites. 5. £15m additional funding secured to support winter contingency and step-in providers. 6. Managed transfer of contracts from NHS Direct to new providers.	1. Established Programme Oversight Group. 2. Established weekly Operational Group. 3. Checkpoint process in place for service rollout.	1. Assurance of higher risk recovery plans undertaken by Deloitte. 2. Gateway review of telephony procurement.	3	3	A	➔	1. Rollout to 3 sites, which will go to established providers. 2. Completion of quality and safety review, and ongoing clinical governance arrangements. 3. Engagement of stakeholders and provider market in development of a vision and business case for NHS 111 future service.	1. 28/02/2014 2. 31/03/2014 3. 31/03/2014	2	2	AG
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 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, and considered by CCG Authorisation and Assurance Committee (ongoing, first committee on 8 Oct 2013). 5. Commissioning development programmes (including area teams) to be aligned across the system. 6. 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. 7. The final CCG assurance framework was published in November 2013 and was the product of comprehensive engagement with stakeholders across the country. From Q3. 2013/14, all assurance conversations will take place on the basis of the final framework.	1. Board reporting on CCG development programme. 2. CCG Assurance Framework has now been approved by the Board and is set to be published by the end of November 2013. The framework will inform all future discussions between NHS England and CCGs. 3. Authorisation Committee review of conditions. 4. Included in the internal audit plan for review.	None identified.	4	3	AR	➔	None identified.				A			

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)			Residual risk progress since last meeting	Further Mitigating Actions	Completion Date for Actions		Anticipated Risk Score Following Mitigation (see note 3)		
			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	9 - NHS mission rights and values	10 - Recruiting, excellent organisation	11 - High quality financial management	Impact	Likelihood	RAG Status				Impact	Likelihood	RAG Status			Impact	Likelihood	RAG Status	Impact	Likelihood
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing 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				
National Director: Commissioning Development Supported by: Chief Operating Officer and National Medical Director	9	<b>Primary Care:</b> 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, CCGs and health and wellbeing boards of local strategic plans for primary care improvement as part of the 2014/15 planning round. 2. Support for CCGs 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	<b>Health Inequalities:</b> 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 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. 31/03/2014 2. Ongoing 3. Ongoing 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	<b>Information Governance:</b> 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	1. 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).	None identified.	4	3	AR	➔	1. Internal Audit of the Information Governance programme initiated (Terms of Reference agreed).	1. 31/03/2014	3	2	A	
Chief Nursing Officer Supported by: Chief Operating Officer	12	<b>Health Visitors:</b> 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	1. This is a particular issue in London and Kent, Surrey, Sussex (KSS) where recovery plans include: • Workstream around rebranding and marketing of Health visiting (London to spearhead). • Work with Health Environment Inspectorate Framework (HEIs) to delay course start to allow sufficient places. 2. Communication pathways for effectiveness have been revised and assessed and are complete. 3. Effectiveness of interventions in the lead up to the next recruitment cohort has been assessed, with London and KSS having detailed recovery plans in place which are challenged and revised on a regular basis. 4. Medway Community Healthcare have confirmed that Band 5 Development posts were in place for February – May 2013, to offer experience for newly qualified staff applying. 5. NHS England is working towards ensuring that sufficient posts are commissioned in line with agreed workforce trajectories, to ensure placements for trained health visitors.	1. Chief Nursing Officer reports to the Board. 2. Included in the internal audit plan for review. 3. Kent and Medway have established a Health Visiting Programme Board. 4. London have developed a Health Visiting Transformation Board.	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	➔	None identified.		3	3	A	
Chief Nursing Officer	13	<b>Compassion in Practice:</b> 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. NHS England's response to the Francis report was consistent with the Compassion in Practice implementation plans. 6. The 6CSLive Communication Hub has been launched and serves as a vehicle to promote best practices in all six action areas. 7. A quarterly review of progress against the implementation plan has been established.	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. Developing measures for success in quality of care in patient experience.	1. 31/01/2014	4	2	A		
National Director: Commissioning Development Supported by: Chief Financial Officer	14	<b>Commissioning Support Services:</b> There is a risk that increasing financial pressures on Clinical Commissioning Groups (CCGs) leads to significant reductions in outsourcing of Commissioning Support Services (CSS) and a shift to in-house provision, resulting in a loss of strategic transformational capability from the system, and potential liabilities.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	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 Commissioning Support Units (CSUs) to ensure they continue to offer high quality & responsive services to CCGs & thrive within the future market. 4. Increasing pace of CSU development (partnering and right-sizing); Make/Share/Buy and In-Housing Impact Assessment advice; ongoing engagement with CCGs.	1. Board reporting on Commissioning Support Units (CSUs) transition programme. 2. Ongoing 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 ongoing independent assessment of Commissioning Support Units (CSUs) financial viability. 2. CSUs will be subject to NHS England's audit arrangements.	4	4	R	➔	1. A programme of ongoing 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 ongoing 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	<b>Transformation of Congenital Heart Services:</b> 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	17	<b>Patient and Public participation:</b> 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 (ongoing). 5. Maternity element of Friends and Family Test went live in October. 6. The Insight Dashboard to drive and enhance public participation has been established.	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. Civil Society Assembly will be launched in March 2014, which will operate as a vehicle and lever for ensuring public participation.	1. 31/03/2014	4	2	A		
Chief Operating Officer	18	<b>Emergency Preparedness, Resilience and Response (EPRR):</b> 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. 5. 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). 6. 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. 7. Forward awareness in respect of national cross government (Tier 1) Pandemic Influenza exercises for delivery into 2014/15 with the majority of the planning taking place in the current fiscal period. 8. Communications exercise testing communication between NHSE DH PHE and other government depts communication teams.	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. 2. A weekly status meeting instigated between NHS England, Public Health England and the Department of Health.	3	3	A	➔	1. Composite report on the lessons identified from regional exercise programmes scheduled.	1. 31/03/2014	2	2	AG		

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)			Residual risk progress since last meeting	Further Mitigating Actions	Completion Date for Actions	Anticipated Risk Score Following Mitigation (see note 3)		
			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	9 - NHS reduction rights and savings	10 - Becoming an excellent organisation	11 - High quality financial management	Impact	Likelihood	RAG Status				Impact	Likelihood	RAG Status				Impact	Likelihood	RAG Status
		Should be high-level potential risks that are unlikely to be fully resolved and require ongoing 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			
National Director: Medical	26	<b>Embedding Outcomes:</b> 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.															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. 4. Domain programme leads and NHS Improving Quality programme leads have established links to ensure alignment between programmes. The process is embedded and will continue to ensure alignment.	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 prioritised and included with business planning process for 2014/15.	1. 31/03/2014	3	2	A
National Director: Commissioning Development Supported by: All	27	<b>Development of Commissioning:</b> There is a risk that some CCGs do not progress beyond the safe threshold achieved in CCG authorisation, which could result in an inability to commission an appropriate level of high quality services for their local population.															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. 6. Publication of the CCG development framework and CCG development support directory focusses on supporting CCGs to progress beyond the threshold achieved in authorisation. 7. The publication of the CCG assurance framework and supporting processes will support CCG development. 8. NHS England have worked with NICE to develop their library of Quality Standards in 2013 and are satisfied that a robust system is in place to enable NHS England to contribute in a useful and appropriate way. 9. Outcomes data from national clinical audits at consultant level in 10 specialties were published by October 2013. Further work is being done to extend and improve the publication of outcome level data to other specialties.	1. CCG Leaders will steer work through the Quality Working Group of the Commissioning Assembly. 2. CCG leaders have oversight of the assurance work through the CCG Development Working Group.	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. CCGs will publish the finance and performance dashboard data on their websites.	1. Ongoing	3	2	A
National Director: Medical	28	<b>Innovation and Research</b> 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.															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	<b>Activity Control</b> 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.															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 (ongoing 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	⬆	1. On-going discussions at the operations executive meeting. 2. The executive team meeting (ETM) to undertake a formal discussion at their meeting on 20/03/2014. 3. Risk to be raised at the Area Team Directors meeting for discussion and management.	1. On-going 2. 20/03/2014 3. 07/03/2014	4	3	AR
Chief Financial Officer Supported by: National Director: Policy	19	<b>Transition - Transfer of Assets and Liabilities:</b> 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.															1. Update reports by Chief Financial Officer (CFO) to the Finance and Investment Committee. 2. Financial reporting to ETM (Executive Team Meeting) and the Board. 3. An accounts direction suggested by the Department of Health in December and recently agreed by HM Treasury will direct that the 2013/14 NHS England financial statements be prepared on the basis that the majority of balances transferring to NHS England and CCGs will be accounted for by NHS England itself. This has reduced significantly the risk that arose from disaggregating the balances between a large number of organisations. This does not affect the legal aspects of the transfer schemes. A dedicated team that reports regularly to the CFO is prioritising completion of all aspects of the accounting for these balances. 4. An accounting environment for legacy items has been developed and resourced accordingly. 5. For assets and liabilities relating to clinical contracts, a consolidated approach to transfer to mitigate the risk associated with disaggregation has been developed. 6. Plan developed for ongoing management of assets and liabilities transferred. 7. PricewaterhouseCoopers have been commissioned to accelerate the completion of the legacy accounting process.	1. The legacy team communicates regularly with the Director of Financial Control, the CFO, the DH and internal and external auditors to ensure all are assured and apprised of progress. This includes review by those individuals of the developing financial position. 2. Included in internal audit plan for review.	1. External audit review of Opening Balances.	3	3	A	⬇	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 risk sharing agreement with Department of Health (DH) and key stakeholders to cover the financial impact of any legacy items.	1. 31/03/2014 2. 31/03/2014 3. 31/03/2014 4. 31/03/2014 5. 31/03/2014 6. 31/03/2014	3	2	A
National Director: HR	21	<b>Human Resources:</b> 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.															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. 31/01/2014 3. 31/03/2014	4	2	A
Chief Financial Officer Support by: National Director: Policy	22	<b>Procurement:</b> 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.															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 Efficiency 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	<b>Dealing with Customer Contacts:</b> 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.															1. Monthly reporting on patient satisfaction with customer contact arrangements established 2. Quarterly reporting on patient contact / complaints established. 3. New process, and additional capacity in place to deal with whole of complaints at local level. 4. Additional capacity in place to clear backlogs and increase response times. 5. Ongoing support and training is provided to facilitate improved service and first time response rate. 6. Regular review of existing Knowledge Articles takes place to ensure they remain accurate. 7. Provision of new Knowledge Articles and 'Question Bank' to provide more information to address callers' queries. 8. Rapid improvement workshop focussing on the complaints process completed. 9. Resource requirements in 2014/15 based on activity levels is being reviewed as part of business planning process. 10. A Learning from Complaints Strategy and action plan has been produced. 11. A sampling of complaints to review the quality of the response for Patient Safety, Patient Experience and Nursing and Safeguarding areas has been completed and further sampling dates have been identified for ongoing quality and safeguarding assurance.	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. 8. Service improvement plan overseen by the Programme Board first meeting 16 December.	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. Implement the recommendations from the Internal Audit review.	1. 30/03/2014	3	3	A

