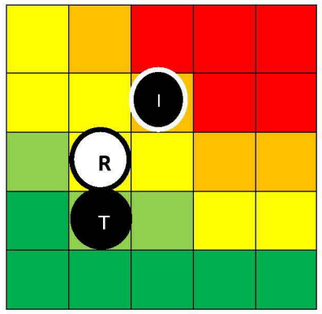
DH Risk Report

No	Risk description and status	Risk category	Risk Owner (DG)	Inherent/ Current Risk	Previous Inherent Risk	Residual Risk	Previous Residual Risk	Target Risk	Trend
1	**Cyber Security** Cyber-attack or inadvertent data loss disrupts operational capacity of the health and care system and risks service delivery, and/or undermines public trust in security and affects the data sharing needed for safe and effective care. Cause(s): (1) Human error, (2) Intentional fraudulent or terrorist attack, (3) Ineffective system controls, (4) Increased use of social media, (5) Increased agile working. Impact(s): (1) Reduction in quality of care, (2) Public confidence undermined, (3) Unacceptable disruption to NHS operational capacity, (4) Making public critical/sensitive/personal data, (5) Unacceptable disruption to the delivery of services.	Strategic	Tamara Finkelstein	A/R (3/4)	A/R (3/4)	A (2/3)	A (2/3)	A/G (2/2)	↔
2	**Major National Infectious Disease Outbreak** Failure to respond and mobilise adequately, as Government lead Department responsible for protecting the health of the population, to a major national infectious disease hazard such as pandemic flu (the highest rated risk on the NRA) or other novel infection; and to maintain and sustain capacity and capability in both the short and longer terms. Cause(s): (1) Not being prepared for a rapid response, (2) Insufficient practice exercises carried out. Impact(s): (1) Widespread infectious disease outbreak, (2) Loss of life, (3) UK infrastructure unable to function effectively.	Strategic	Felicity Harvey	R (3/5)	R (3/5)	A (2/4)	A (2/4)	A (2/3)	↔
3	**Antimicrobial Resistance** DH and the wider global response to antimicrobial resistance is inadequate. Cause(s): (1) Poor infection prevention and control, (2) inappropriate use of antibiotics, (3) no new antimicrobials in the development pipeline. Impact(s): (1) Many standard medical treatments become high risk procedures, (2) Previously treatable infections become untreatable.	Strategic	Felicity Harvey	R (4/5)	R (4/5)	A/R (3/4)	A/R (3/4)	A (2/3)	↔
4	**Workforce (Health & Care System)** When in financial balance, failure to meet demand for sufficient capable and affordable staff across the health and care system. Cause(s): (1) Current plans do not adequately account for the workforce requirements of new models of care delivered in different settings, (2) Funding pressures makes recruitment and retention difficult. Impact(s): (1) Safe staffing issues, (2) Decline in quality of care, (3) Spending on temporary staff.	Strategic	Charlie Massey	R (4/4)	R (4/4)	A (2/4)	A (2/4)	A (2/3)	↔
5	**Leadership (Health & Care System)** **Awaiting risk content.** A lack of strong leadership and inadequate succession planning across the health and care system. Cause(s): (1) Funding pressures mean high calibre candidates cannot be appointed or retained, (2) Insufficient pool of high calibre candidates. Impact(s): (1) Failure in delivering the Five Year Forward View, (2) Failure to deliver the £22bn system efficiencies and productivity targets, (3) An increasingly dysfunctional health and care system.	Strategic	David Williams / Charlie Massey	TBC	TBC	TBC	TBC	TBC	
6	**DH Capability and Capacity** **Risk definition under review** DHs capability and capacity to steward the health and care system is adversely affected. Cause(s): (1) A reduced pay bill and stringent headcount targets with increasing productivity pressure on remaining staff. Impact(s): (1) Directorates face natural turnover of more talented staff while retaining weaker performers who cannot be exited, (2) The capability of the Department to deliver against its objectives would be reduced.	Strategic	Tamara Finkelstein	A/R (4/3)		A/G (3/2)		A (3/3)	
7	**Quality and safety** A DH system stewardship failure could lead to a widespread loss of focus on sustainable quality care. Cause(s): (1) Over focus on key targets and finance, (2) Staffing pressures. Impact(s): (1) Unacceptable variation in the safety and provision of care, (2) Unacceptable level of poor care.	Strategic	Charlie Massey	A/R (3/4)	A/R (3/4)	A (3/3)	A (3/3)	A (3/3)	↔
8	**Failure to comply with the health inequalities legal duties and with the Public Sector Equality Duty** Failure of the health system (DH, Executive Agencies and Special Health Authorities, NHS England and CCGs) to comply with their health inequalities duties, or failure of DH to comply with the Public Sector Equality Duty , and a failure to achieve the headline Shared Delivery Plan (SDP) metric of reducing inequalities in Life Expectancy and Healthy Life Expectancy. Cause(s): (1) Lack of knowledge, (2) Capacity and capability, (3) Ineffective use of levers across the health system or within DH. Impact(s): (1) DH or health system at risk of Judicial Review, or of compliance action by the Equality and Human Rights Commission, (2) Reputational damage through the Department's stewardship of an effective health system being called into question, (3) Widening health inequalities cause higher morbidity and mortality, increasing demand for NHS and Social Care services.	Strategic	Jon Rouse	R (4/4)	A (3/3)	AR (3/4)	A (3/3)	A (2/4)	↑
9	**Climate Change – risk moved to PIHD risk register**								
10	**Obesity** **Revised wording following proposal to manage diabetes and obesity risks separately** The Government's strategy on childhood obesity is not delivered leading to significant increased costs of obesity-related ill health. Cause(s): (1) The UK has one of the worst records for childhood obesity amongst developed countries with 1 in 10 obese at age 4, and 2 in 10 obese by age 11. This risk is caused by a number of inter-related factors, including, but not limited to: 1) awareness of healthy eating and physical exercise; 2) availability and advertising of low cost, unhealthy food, 3) levels of physical exercise 4) failure to take action in early years. 5) the limited action on obesity by families and schools. Impact(s): Significant effects to longer term health in Britain which are costly both in terms of need for health services and have a debilitating effect on the economy through ability to participate in work and cost of benefits	Operational	Felicity Harvey	R (3/5)	R (3/5)	A (1/5)	A (1/5)	A/G (1/3)	↔
11	**Adult Social Care System Failure** Financial position of local government, and fragility of ASC market and workforce, leads to systemic or individual failings in ASC services, and broader failure of Government to realise benefits of Care Act. Cause(s): (1) SR Settlement, (2) LAs driving savings from provider fee rates, (3) LAs prioritising funding away from social care to other local government services, (4) providers exiting the market. Impact(s): (1) Rising unmet need and declining quality, (2) Care Act benefits not realised, (3) Possibility DH/DCLG intervention in LA required, (4) Increased pressure on NHS, (5) NHS pull back from further integration and risks to success of devolution deals, (6) Increased number of providers exit market and lack of new investment in services for those funded by the state, (7) Reduced number of people receiving publicly funded ASC, (8) Decline in outcome measures, (9) Increased pressures on carers and the voluntary sector, (10) Workforce shortages and lack of long term capacity planning for sector, (11) Reduced resilience for sector to manage major incidents.	Operational	Jon Rouse	R (4/4)	R (4/5)	R (4/4)	R (3/5)	A (3/3)	↔
12	**Financial sustainability of health and care system** Failure to deliver a sustainable health and care system while maintaining key financial targets (Adult social care sustainability care dealt with in risk 11). Cause(s): (1) Targets are unrealistic and unachievable, (2) Unforeseen additional demand. Impact(s): (1) Unaffordable health and care system, (2) Reduction in the quality and access to care, (3) Diverted focus from FYFV implementation.	Operational	David Williams	R (4/4)	R (4/4)	A/R (3/4)	A/R (3/4)	tbc	↔
13	**Performance of the health and care system** Failure to achieve and maintain key access targets. Cause(s): (1) Funding pressures, (2) Unsustainable demand. Impact(s): (1) A reduction in the quality of and access to care, (2) Diverted focus from FYFV implementation.	Operational	David Williams	R (5/5)	R (5/5)	A/R (3/4)	A/R (3/4)	tbc	↔

14	**Workforce – Junior Doctors** **Request to remove this tactical risk which has materialised** DH fails to negotiate successfully with Junior Doctors threatening strike action regarding the proposed changes to their contracts. Cause(s): (1) Junior Doctors have agreed to ballot for industrial action over proposed contract changes. Impact(s): (1) Risk to front line service delivery if strike action goes ahead, (2) Negotiations may not be able to keep within the required costs envelope.	Tactical	Charlie Massey	R (4/4)		A (2/4)		A/G (1/3)	↔
15	**Implementation of technology programmes** There is a risk that implementation of Paperless 2020 does not meet NHS/ Social Care needs or match patients/service user expectations. Cause(s): (1) Delay to mobilisation and lack of pace, (2) Lack of capability and capacity to manage and deliver the programmes of work, (3) Insufficient funding to support activity in critical years, (4) Further changes to system governance create instability and introduce delay to delivery and increase the risk to the department, (5) Lack of strategic focus and planning, (6) Insufficient focus on user/system need, (7) Front line organisations unable/slow/unwilling to implement. Impact(s): (1) Fails to deliver key requirements and risk critical business operations on time, affecting organisations, patients and care users, (2) Unable to generate pace across the portfolio and manage dependencies effectively, (3) Reputational damage, lack of confidence in DH and ALBs to manage complex portfolio and drive transformational change, (4) PH&C2020 and FYFV targets are not met, (5) Contributions to £22bn efficiency savings are not met, or slower than expected, (6) Unable to maximise funding allocation from SR.	Strategic	Tamara Finkelstein	A/R (3/4)		A (2/3)		A/G (2/2)	↔



1. Cyber Security – update cleared by Katie Farrington

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
IGT	Tamara Finkelstein	09.07.15	25.04.16	Strategic

Risk Description:

Risk: Cyber-attack or inadvertent data loss disrupts operational capacity of the health and care system and risks service delivery, and/or undermines public trust in security and affects the data sharing needed for safe and effective care.
Cause(s): (1) Human error, (2) Intentional fraudulent or terrorist attack, (3) Ineffective system controls, (4) Increased use of social media, (5) Increased agile working.
Impact(s): (1) Reduction in quality of care, (2) Public confidence undermined, (3) Unacceptable disruption to NHS operational capacity, (4) Making public critical/sensitive/personal data, (5) Unacceptable disruption to the delivery of services.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	3	Impact	4	AMBER/RED	3/4 AMBER/RED	Likelihood	2	Impact	3	AMBER	2/3 AMBER	↔	Likelihood	2	Impact	2	AMBER/GREEN

Background

To improve cyber-governance, DH has established the Information Security & Risk Board (ISRB). The Board will provide system-wide leadership on cyber-risk issues. DH are establishing the Board's primacy over system-governance, and developing clear escalation & accountability points for its interaction with the wider system.
In order to build up the system's capacity to provide a collective response to cyber incidents, HSCIC has established CareCERT - a strategic cyber risk oversight capability that will provide situational-awareness monitoring of active risks on behalf of the system. This model will essentially work in the same way as other cross-Government models (e.g. CERT-UK and Gov-CERT) and will, first and foremost act as a mechanism for disseminating information about specific and general risks (and the appropriate response to them) and as a point of co-ordination for collective activity in the event of cyber-attack. Phase 1 (the capability to broadcast alerts across the system) of CareCERT launched in October 2016, and full-scale protective monitoring will be introduced in Q1 2016.
In September 2015 the Secretary of State announced a review into standards of data security, to be led by Dame Fiona Caldicott. The review's aim is to deliver a clear set of cyber security principles that can be applied consistently across all sectors of the health and care system. Dame Fiona and CQC working together will deliver a clear method for evaluating compliance with those new principles though the CQC and NHS England regulatory regimes. A single set of principles will seek to provide clarity about roles and responsibilities and ensure that cyber security is treated as seriously as maintaining hygiene in our wards and other clinical settings. The review's publication has been delayed due to the EU referendum and it is now due to be published in the summer. It is likely that the review will recommend clear data security standards grouped around three themes of people, processes and technology. Specific recommendations are likely to include:

- Mandatory cyber training for all employees
- Computer hardware and software that can no longer be supported should be replaced as a matter of urgency
- All organisations should provide evidence that they are taking action to improve cyber security, for example through the cyber essentials scheme
- Where malicious or intention data security breaches occur, the Department should put harsher sanctions in place to ensure redress.

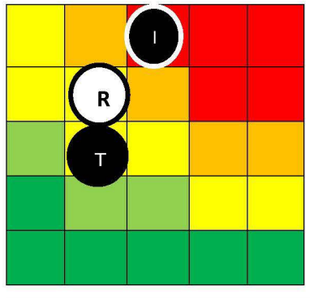
It is likely that organisations will be required to adhere to these standards through their financial contracts and that adherence will be assessed though internal audit and external inspection. Compliance against the standards and recommendations included in the review (reported through a revised data security toolkit) should considerably reduce the vulnerability of the system in relation to the most common and frequent cyber-attacks (by increasing the awareness of the workforce, thereby reducing the threat from human behaviours, and by establishing a consistent minimum standard of cyber security).
As lead department for the health and care sector in England, DH must ensure that key business assets of all types are appropriately risk assessed, protected, and are resilient to loss or disruption. This requirement includes informatics assets that provide or enable nationally important services. The current list of critical health informatics assets is being refreshed and extended as entries are outdated and potentially not comprehensive. This identification and assessment of assets is also being extended outwards to all ALBs (as opposed to being limited to the assets that HSCIC have technical oversight for). The final list has been compiled and will be scrutinised for wider consideration by the CSOF and ISRB in Q1 2016.
The SIRO (Senior Information Risk Owner) network is being strengthened and made accountable to the ISRB. The ISRB will sponsor the development of a suitable and consistent "job description" for the SIRO function, setting clear parameters for roles and responsibilities and mandating that, where appropriate, the SIRO should either be a Board member, or linked to a lead/named Director.
A new executive group of the Cyber Security Leadership Forum has also been introduced to act as the link between the ISRB and the CSOF and oversee the delivery of a range of activities to be executed at operational level.

Response plan (further activities/mitigations):

Activity	Action Owner	Due date	Action update
1. NRA cyber risk being broadened to reflect threat to data as system's 'Key Asset'.	Tamara Finkelstein	July 2016	First draft produced. Further iteration (and economic impact assessment) was finalised on 8th March.
2. Development of CareCERT – strategic Cyber risk oversight capability on behalf of H&C system.	Tamara Finkelstein (delivered through HSCIC)	Q1 2016	Threat intelligence and initial protective monitoring in place. Full scale protective monitory for Spine will be achieved in either May or July (decision pending).
3. Detailed security planning and incident reporting built into Open Service ICT contract (monitored by DH security team & equivalents in Open Service partner orgs). Security risks are monitored and issues may be raised with the Security Expert Advisory Group, which reports to the Director, E&IS. Effectiveness of security controls regularly checked by accredited independent consultants.	Dom Brankin	Ongoing	
4. Implement and embed new cyber security standards proposed by Dame Fiona Caldicott throughout system.	Tamara Finkelstein	Dependent on the outcome of the Cyber	The review is due to be published summer 2016; this delay has been caused by the timeline of the EU referendum.

		Security Review	
5. Liaising with Cabinet office and security agencies to implement best practices on management of cyber CNI and the NRA cyber risk. Working with Cabinet Office to explore impact of future regulation of CNI and the establishment of the National Cyber Centre.	Tamara Finkelstein (delivered through HSCIC)	Ongoing	ALBs provided details and categorisation of Cat 3 CNI by 18th Feb. All organisations provided details of anything below Cat 3 on 18th March. Input is still being sought from ALBs not represented on Cyber Security Operations Forum (NHSBT and MHRA).
6. Education and training: develop and launch an online cyber training platform to ensure that the relevant skills of all health and care staff are increased and that they have access to appropriate support resources. Develop and launch HCISPP qualification – 100 individuals to benefit from targeted learning and become cyber-security champions for their organisations.	Tamara Finkelstein (delivered through HSCIC)	Summer 2016	The level 1 course is ready to be uploaded and made available to 400,000 eLearning for Health users on 8th April 2016. See annex 1 – Level 1-3 course syllabus for more detail. The Cyber Security Programme has asked the Department of Health to make a decision as to whether the project releases each course with the pending National Data Guardian report due to be issued in Summer 2016.
7. Launch a new Data security toolkit to expand on, and improve, the Information Security Toolkit: the revised toolkit will be the central point at which organisations report their compliance against the new standards proposed in the data security review (including mandatory cyber training and replacement of out of date software. Additionally, it will track progress against the recommendations in the review, such as the achievement of a minimum cyber standard. Achieving compliance against the standards in the revised toolkit will strongly reduce the vulnerability of organisations to cyber threats.	Tamara Finkelstein (delivered through HSCIC)	Autumn 2016	The final content of the revised toolkit will be informed by the standards and recommendations put forward by the data security review when it is published in summer 2016.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)
Recent TalkTalk cyber-attack has highlighted this risk in the media.



2. Major National Infectious Disease Outbreak

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
PIHD	Felicity Harvey	Pre 2013	22.04.16	Strategic

Risk Description:

Risk: Failure to respond and mobilise adequately, as Government lead Department responsible for protecting the health of the population, to a major national infectious disease hazard such as pandemic flu (the highest rated risk on the NRA) or other novel infection; and to maintain and sustain capacity and capability in both the short and longer terms.
Cause(s): (1) Not being prepared for a rapid response, (2) Insufficient practice exercises carried out
Impact(s): (1) Widespread infectious disease outbreak, (2) Loss of life, (3) UK infrastructure unable to function effectively

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	3	Impact	5	RED	3/5 RED	Likelihood	2	Impact	4	AMBER	2/4 AMBER	↔	Likelihood	2	Impact	3	AMBER

Background information

Influenza pandemics are natural phenomena that have occurred over the centuries, including three times in the 20th century and most recently the 2009 H1N1 influenza pandemic. The symptoms caused by an influenza pandemic are similar to those of seasonal influenza but may be significantly more severe. Influenza pandemics arise because of new influenza viruses that are markedly different from recently circulating influenza viruses. This means that few people, if any, have immunity. The rapid spread from person to person which can take place during pandemics can have significant global human health consequences. Pandemic influenza is the most significant civil emergency risk to the UK.

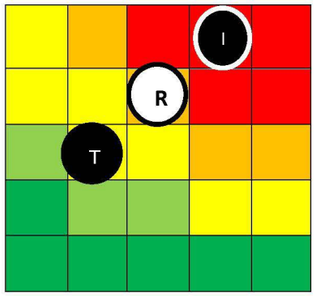
An emerging infectious disease can be defined as a disease that has recently been recognised or a disease for which cases have increased over the last 20 years, in a specific place or among a specific population. Most of these newly recognised infections are zoonotic, that is they are naturally transmissible, directly or indirectly, between vertebrate animals and humans. By their very nature, zoonotic infections can be more challenging to monitor. Although it is unlikely that a new infectious disease will originate in the UK, it is highly probable that one will emerge in another country. Given the ease and speed with which people can travel around the world, a new infection could spread rapidly before it is detected, and be transmitted to the UK. New diseases therefore pose a potential threat to the health of the UK population, and may present social and economic challenges.

Response plan (further activities/mitigations):

Activity	Action Owner	Due date	Action update
1. Pandemic influenza - A Tier 1 exercise, Cygnus (part 2), is scheduled for October 2016 and will test preparedness across the health and social care sector, providing assurance as well as identifying areas for the future work programme. In addition a health sector workshop will also be held in July 2016 which will provide an opportunity for system-wide consideration of some of the health and care issues arising out of the Cygnus Tier 1 exercise (part 1) held in 2014 and work which has taken place to address them.	Helen Shirley-Quirk/Graeme Tunbridge	July and Oct 2016	Planning in progress; good level of preparedness for exercise and wide engagement across health and broader sectors.
2. Pandemic influenza - clear governance and oversight of work programme across NHS England, PHE and DH through the Pandemic Influenza Preparedness Programme Board. A new policy for managing extreme surge and population triage arrangements in England in the event of a severe influenza pandemic is being developed and will be considered by the Departmental Boards of DH, NHS England and PHE.	Helen Shirley-Quirk/Graeme Tunbridge	Ongoing and May	2. Ongoing. Extreme surge and population triage to be considered by Departmental Board in May 2016. Next PIPP Board meeting in September 2016
3. Pandemic influenza - programme to re-contract the National Pandemic Flu Service (NPFS) was subject to an MPA Gateway review which resulted in a new Programme Director being appointed and regular Delivery Board meetings. A second IPA review took place in February 2016.	Helen Shirley-Quirk/Graeme Tunbridge	June 2016	6/10 actions have been actioned and the remainder are in progress. A programme review was suggested as critical action and the programme director undertook this as his first task. His assessment was that technical readiness was in a good place and initial testing was positive. An Amber-Green Delivery Confidence Assessment was achieved in the Feb 2016 IPA review.
4. Emerging infectious disease - Programme being jointly developed and implemented with PHE and NHS England. Governance for this programme will be through individual NHS England and PHE Programme Boards, a weekly tripartite Health Delivery Group meeting and a quarterly EPRR Partnership Group to provide more strategic oversight.	Helen Shirley-Quirk/Graeme Tunbridge	Apr 2017	4. First NHS England Programme Board held in November 2015; first substantive update to EPRR Partnership Group in Mar 2016.
5. Exercise to test preparedness for Middle Eastern Respiratory Syndrome (MERS) took place in February 2016 and E.coli exercise planned for October 2016.	Helen Shirley-Quirk/Graeme Tunbridge	Oct 2016	5. Excellent feedback on usefulness of MERS exercise with a number of actions for PHE, NHE England and DH to take forward.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)

Context: Transition to a new NPFS IT system is subject to compliance with Government Digital service (GDS) requirements. In line with Cabinet Office requirements, the new service will be delivered by a variety of third party organisations and responsibility for integrating these different components will rest with the public sector (HSCIC).



3. Antimicrobial Resistance

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
PIHD	Felicity Harvey	Pre 2013	22.04.16	Strategic

Risk Description:

Risk: DH and the wider global response to antimicrobial resistance is inadequate.
Cause(s): (1) Poor infection prevention and control (2) inappropriate use of antibiotics, (3) no new antimicrobials in the development pipeline.
Impact(s): (1) Many standard medical treatments become high risk procedures, (2) Previously treatable infections become untreatable.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	5	RED	4/5RED	Likelihood	3	Impact	4	3/4 AMBER/RED	3/4 AMBER/RED	↔	Likelihood	2	Impact	3	AMBER

Background

AMR is a global issue, the UK is responding through implementation of its 5 year UK AMR Strategy (2013- 2018). This focuses on activity at national and international level to combat AMR using a One-Health approach.

Actions to mitigate the risk are all captured in the UK plan. Via the integrated UK plan, PHE, VMD and NHS England all have Senior Responsible Officers for individual parts of the overall programme.

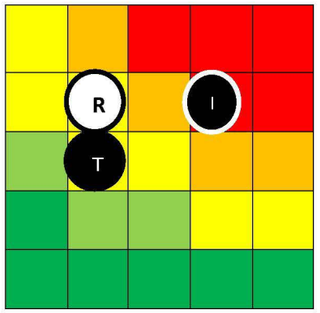
The implementation plan for the cross government strategy is monitored through outcome measures and overseen by the Cross-Government High Level Steering Group which meets three times a year and publishes an annual progress report. All partners committed to delivery as reflected in their plans, which are monitored monthly.

Good progress has been made on implementing the deliverables in the UK Strategy, especially in areas such as surveillance (the first "One Health" surveillance report covering both human and animal published), stewardship (NICE guidance published) and in the international arena, with AMR resolutions passed at the World Health Assembly and at the Food and Agriculture Organisation (FAO) and the world animal health organisation (OIE). AMR has been included in the NHS five year forward plan and is a priority patient safety issue for CCGs. AMR is referred to in both the National Risk Register of Civil Emergencies for 2015 and in the National Security Risk Assessment (NSRA) as a Tier One risk to global health security. New £265 million Fleming Fund to strengthen surveillance of drug resistance and laboratory capacity in developing countries

Response plan (further activities):

Activity	Action Owner	Due date	Action update
(1). New global AMR Innovation Fund launched with China, bringing in a broad range of international partners	Helen Shirley-Quirk	Innovation Fund currently at planning stage	A revised UK plan, which provides an assessment of progress of the programme and mitigating actions, was discussed at the HLSG meeting on 1 March, and was approved (subject to amendments) by the group.
(2). We are assessing the impact of our current interventions however and looking to shift our focus from national deliverables to empowering local areas to deliver. Revised work programme with an increasing focus on local action currently in discussion with partners	Tim Baxter	Revised plan for approval Mar 2016	
(3). PHE and NHS England are developing a network of clinical leaders to push forward action at the local level	Name Redacted		Successful leaders' workshop held 21 March. PHE and NHS England have two further workshops planned.
(4). Linking this agenda to Secretary of State's aim to promote action on hospital-acquired infection	Tim Baxter / Ailsa Wight	New campaign March 2016	
(5). Work to take forward recommendations of the independent Review - formal governance structure for overseeing response to O'Neill review being put in place	Felicity Harvey	Response to Review June 2016	
(6). Priority is to hold a high level meeting at the UN General Assembly in 2016, to build the momentum of international activity	Name Redacted (FCO lead)	UNGA September 2016	
Formal evaluation of strategy commissioned to help adapt strategy further as necessary from 2017			

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



4. Workforce (Health & Care System) – update cleared by Giles Denham

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
SER	Charlie Massey	Aug 2014	25.04.16	Strategic

Risk Description:

Risk: When in financial balance, failure to meet demand for sufficient capable and affordable staff across the health and care system
Cause(s): (1) Current plans do not adequately account for the workforce requirements of new models of care delivered in different settings (2) Funding pressures makes recruitment and retention difficult; (3)
Impact(s): (1) Safe staffing issues , (2) Decline in quality of care (3) Spending on temporary staff .

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	4	RED	4/4 RED	Likelihood	2	Impact	4	AMBER	2/4 AMBER	↔	Likelihood	2	Impact	3	AMBER

Background

The relatively long time lags between the commissioning of training places/ commencement of training and completion of training by staff mean that consideration has to be given to the workforce requirements of the future NHS and social care. At a time of rapid transformation of services (Vanguards, New Models of Care, challenging efficiency requirements), there is an increased risk that the workforce planning and training processes may not yield the "correct" mix of skills, staff types and specialisms required by our future workforce.
The Government has confirmed public sector pay will be capped at 1% over the next 4 years 2016/17 to 2019/20 with any pay award targeted towards recruitment and retention issues.
The BMA Consultants Committee and NHS Employers have resumed negotiations on reform of that contract.
Junior doctors voted for industrial action in a ballot conducted by the BMA. Following Sir David Dalton's recommendation that an agreement was not achievable, Secretary of State announced on 11 February the new contract for juniors would be introduced from August. BMA announced further strikes starting on 9 March. Risk of continuing service disruption. Contractual cost neutrality maintained.
AfC TUs will be asked to enter into negotiations for implementation from April 2017. National collective bargaining will reduce the risk of IA, but both sets of negotiations will be challenging against a background of prolonged pay restraint.

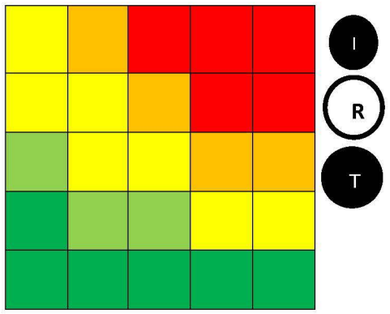
There are insufficient nurses to meet demand across the health and care sector: Changes to the immigration policy make international recruitment more difficult, an agency nursing cap reduces supply, Increased numbers of UK trained nurses are not available until 2017 and return to practice campaigns have not produced as many returners as in previous campaigns; leading to the quality of care falling.
Existing programmes of work on workforce in the adult social care sector are making progress but overall their impact is limited, there are significant concerns about quality in the sector (particularly nursing homes and turnover continues to increase (another 1% in the past year) – a number of emerging threats (continuing financial squeeze; shortages of nurses and registered managers; tightening immigration controls; National Living Wage, etc) are placing additional strain on the sector.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Proceed with contract reform for Consultants, Junior Doctors and Agenda for Change groups	Tim Sands	April 2016	Negotiations with consultants have progressed positively, but recent cross-government agreement they should be paused at least until after the EU referendum. Establishment of Implementation and Engagement Board to assure delivery of new junior doctor contract (involving DH, NHSI, NHSE and HEE).
2. Target pay awards to support implementation of new contracts and transitional arrangements that TUs are likely to support, which is being explored with the Cabinet Office and HM Treasury	Tim Sands	To meet annual Pay Review Body Timetable	Review Bodies both recommended 1% uplifts for 2016/17
3. Improve workforce productivity - the Model Hospital will identify indicators and benchmarks for hospital staffing	Name Redacted	Sept 15 has slipped – see action update	Some indicators and benchmarks have now been developed and are being used in the discussions between Lord Carter and individual Trusts
4. Agree with Home Office a plan to mitigate the effect of immigration policy changes on the health and care workforce and to open up recruitment through other innovative routes eg under Tier 5 Prepare and Present cogent shortage argument to MAC to maintain key areas of nursing, currently in shortage, on the Shortage Occupation List		Oct 2015	Plan is now complete. Short term agreement to put nursing on the Shortage Occupation List. Submission has gone to MAC recommending some nursing groups are added to the list for the longer term. Further discussions cross government to mitigate the effect of proposed changes to Tier 2 immigration rules and the health and car workforce.

			Nurses were added to the Shortage Occupation List in December 2015. Following a call for evidence and a further review of the UK nursing recruitment requirements by the independent migration Advisory Committee, nursing will remain on the Shortage Occupation List until July 2019, when a further review is planned. However, employers will need to carry out a resident labour market test before recruiting a non EEA nurse and the immigration Skills Charge, currently one thousand pounds for each year that the employee is contracted to work within the UK. This move is designed to help the NHS improve continuity of care for patients, invest in the frontline and maintain safe staffing levels, whilst incentivising employers to invest in up-skilling the resident workforce.
5. HEE actions to make available 10,000 more staff (including 5000 doctors) to work in Primary Care by 2020.	HEE (monitored by DH Sponsorship team)	Ongoing	HEE has begun work with RCN and others on return to practice programmes HEE workforce plan includes planned reduction in level of attrition from training programmes Recent involvement with NICE Safer Staffing Steering Group work programme has helped identify additional pressures and avoid the use of simplistic staffing ratios Implement controls on costs of agency staff used in NHS, through TDA and Monitor
6. Undertake a range of supply side interventions to support a sustainable adult social care market and attract and retain social care workers.	Name Redacted SCLGP)	Ongoing	State of the market pack presented to Jeremy Heywood and welcomed. Now establishing work plan, resources and governance. The new Adult Social Care Workforce Strategy addresses a range of policy issues affecting the workforce.
7. Raise awareness of workforce planning processes, likely future demands and supply restrictions across DH leadership	Andrew Sanderson (for ExCo)	Ongoing	
			Further Updates: - HEE has begun work with HEE with RCN and others on return to practice programmes - HEE workforce plan includes planned reduction in level of attrition from training programmes - Recent involvement with NICE Safer Staffing Steering Group work programme has helped identify additional pressures and avoid the use of simplistic staffing ratios - Implement controls on costs of agency staff used in NHS, through TDA and Monitor

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



5. Leadership (Health & Care System)

Directorate	Risk Owners	Date risk identified	Date last reviewed	Risk Category
FC&NHS and SER	David Williams and Charlie Massey	July 2015		Strategic

Risk Description:

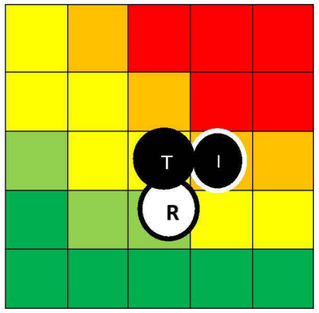
Risk: A lack of strong leadership and inadequate succession planning across the health and care system.
Cause(s): (1) Funding pressures mean high calibre candidates cannot be appointed or retained, (2) Insufficient pool of high calibre candidates
Impact(s): (1) Failure in delivering the Five Year Forward View, (2) Failure to deliver the £22bn system efficiencies and productivity targets, (3) An increasingly dysfunctional health and care system.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood		Impact			n/a	Likelihood		Impact					Likelihood		Impact		

Background

Response plan (further activities):			
Activity	**Action Owner**	**Due date**	**Action update**

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



6. DH Capability and Capacity – risk definition under review

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
GO	Tamara Finkelstein		19.02.16 risk definition under review	Strategic

Risk Description:

Risk: DHs capability and capacity to steward the health and care system is adversely affected.
Cause(s): (1) A reduced pay bill and stringent headcount targets with increasing productivity pressure on remaining staff.
Impact(s): (1) Directorates face natural turnover of more talented staff while retaining weaker performers who cannot be exited, (2) The capability of the Department to deliver against its objectives would be reduced.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk - TBC				
Likelihood	4	Impact	3	AMBER/RED	n/a	Likelihood	3	Impact	2	AMBER/GREEN	n/a		Likelihood	3	Impact	3	AMBER

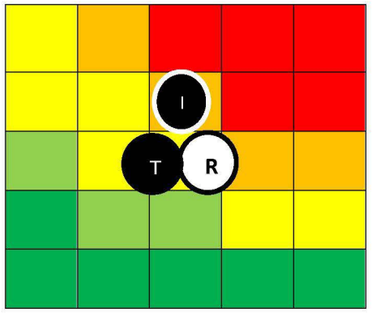
Background

As the strategic partner with a focus on people, HR provides advice, guidance, policies and processes which are the enablers for line managers to work with their members of staff to achieve the organisation's objectives. With the Spending Review and the plans for DH2020 as well as the Civil Service performance management process, there is a focus on ensuring that the right people are available to do or to be moved to doing the work required to achieve results. This coupled with continued pay restraint is likely to have an adverse impact on the department's capability and capacity to deliver what is needed.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Improve the robustness of performance management to improve the average performance levels and to exit staff who are under performing.	HR and line managers	Ongoing	500 staff members underwent performance management training sessions in September and October
2. Ensure that our corporate fast stream programme is well run and attracts the fast streamers to join the department at the end of their placement.	HR and line managers	Ongoing	The fast stream team gives targeted support and development to both line managers and corporate fast streamers
3. Invest in the development of, and provide stretch postings to our most talented people as a retention mechanism.	HR and line managers	Jan 2016	HEO/SEO development centres and Leading with Impact programmes launched
4. Develop a capability plan to address the core capability gaps identified by the department.	HR	Q1 2016 launch	Digital capability tool was designed and launched
5. Develop high quality rigorous selection processes and invest in training interviewers to ensure that where we can recruit into the department we recruit the highest quality people.	HR	Ongoing	Work is being done to scope training for independent assessors to sit on selection panels
6. Develop clearer leadership expectation and direction, and build SCS confidence in leading through the uncertainty ahead.	DH SCS	Ongoing	Embedding the Leadership Statement, Leading through Change discussions at Leadership Forum and intend to roll out the SCS 360 degree feedback tool developed by CSL in January/February
7. Consider managing additional reductions in headcount to fund exit strategies and seek approval from treasury for a “refreshment based” exit programme.	HR	Ongoing	Being considered as part of DH2020 planning and discussions

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



7. Quality and safety – updated cleared by William Vineall

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
SER	Charlie Massey	Aug 2014	25.04.16	Strategic

Risk Description:

Risk: A DH system stewardship failure could lead to a widespread loss of focus on sustainable quality care
Cause(s): (1) Over focus on key targets and finance, (2) Staffing pressures
Impact(s): (1) Unacceptable variation in the safety and provision of care, (2) Unacceptable level of poor care.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	3	Impact	4	AMBER/RED	3/4 AMBER/RED	Likelihood	3	Impact	3	AMBER	3/3 AMBER	↔	Likelihood	3	Impact	3	AMBER

Background

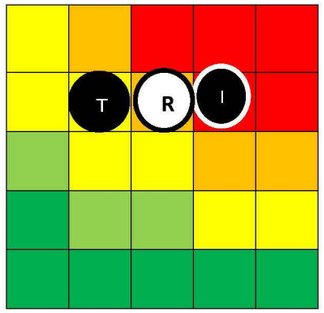
A DH system stewardship failure could lead to a widespread loss of focus on sustainable quality care and thus to: -
i) Catastrophic localised service failures (and high profile incidents causing severe harm to individuals in the short term), and/or
ii) A widespread deterioration in service quality (resulting in worsening population level outcomes in the medium to long term) ; and therefore causing A) serious reputational damage to DH; B) extensive loss of public confidence in the NHS; C) additional and unsustainable pressure on NHS finances and D) a significant and attributable adverse trend in avoidable mortality.

The underlying causes of the risks are:-
Shifts in national and local agendas could lead to a loss of focus on Francis agenda, particularly safety and compassion
Current NHS deficits start to infringe on quality of care
ALBs fail to deliver on actions assigned to lack of resources, competing priorities and potential disagreement over action plans
Local agencies do not engage sufficiently with the agenda and momentum is lost
NHS England will hand over its system leadership role on safety to NHS Improvement, as it focuses on its own new vision of its functions

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Through the Shared Delivery Plan and SR process ensure that quality is aligned with the case for greater efficiency and productivity.	Jason Yiannikkou	April 2016	Existing controls include: - Strengthening the system leadership for patient safety, ensuring a coherent system-wide approach to improvement. Including the coordination of the Secretary of State 'Care Delivery' meetings and through the alignment across the system leadership landscape - Promoting a culture that supports the highest quality of care, delivers improved outcomes for populations, reduces inequalities and uses resources efficiently (in the context of the challenges set out in the 5 Year Forward View) - Ensuring that CQC, NHS England, NHS Improvement and other delivery partners work together effectively to improve the quality of care in providers, making our hospitals the safest in the world; including by managing the regime by ensuring that CQC's approach to inspection is sufficiently robust and by helping to develop policies to implement a 7 day NHS - Work started in earnest with CQC and NHSI. This includes joint letter from NHSI-CQC (Mike Richards & Jim Mackey) regarding quality and finance matters was sent in January. Respective roles re the new efficiency indicator being agreed.
2. Active management with NHS England and the National Director for Patient Safety on the transfer of the national safety functions to NHS Improvement	Jason Yiannikkou	April 2016	
3. Support and guidance to those leading on the coordination of a global summit for safety and onward global movement for safety.	Jason Yiannikkou	Ongoing	
4. Support and monitor the implementation of the recommendations contained in 'Learning not Blaming' publication.	William Vineall	Dec 2016	
5. Work with NHS Improvement and NHS England to ensure the production of safe staffing guidance.	Jason Yiannikkou	Dec 2016	
6. Working with DH Finance, NHSI and CQC to ensure quality and finance go hand in hand.	William Vineall	Ongoing	
7. Analysts developing a new tool to facilitate detection of quality deteriorations at a national level	Jason Yiannikkou	Ongoing	

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



8. Failure to comply with the health inequalities legal duties and with the Public Sector Equality Duty

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
SCLGCP	Jon Rouse	Pre 2013	22.03.16	Strategic

Risk Description:

Risk: Failure of the health system (DH, Executive Agencies and Special Health Authorities, NHS England and CCGs) to comply with their health inequalities duties, or failure of DH to comply with the Public Sector Equality Duty and a failure to achieve the headline Shared Delivery Plan (SDP) metric of reducing inequalities in Life Expectancy and Healthy Life Expectancy.

Cause(s): (1) Lack of knowledge, (2) Capacity and capability, (3) Ineffective use of levers across the health system or within DH
Impact(s): (1) DH or health system at risk of Judicial Review, or of compliance action by the Equality and Human Rights Commission, (2) Reputational damage through the Department's stewardship of an effective health system being called into question, (3) Widening health inequalities cause higher morbidity and mortality, increasing demand for NHS and Social Care services.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	4	RED	3/3 AMBER	Likelihood	3	Impact	4	AMBER/RED	3/3 AMBER	↑	Likelihood	2	Impact	4	AMBER

Background information

New duties on health inequalities for Secretary of State, NHS England, and CCGs were introduced by the Health and Social Care Act 2012 that require Secretary of State to have regard to the need to reduce health inequalities. The Public Sector Equality Duty (PSED) is included in the Equality Act 2010 and requires Secretary of State to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations. There are two major risks associated with these legal duties:

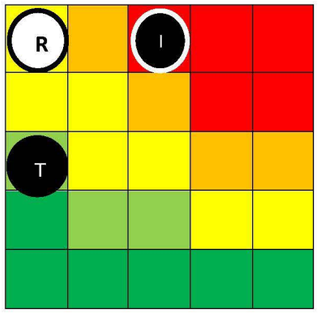
1) **Failure to comply with the legal duties.** A failure to comply puts the Department at risk of a judicial review or regulatory enforcement. The residual risk rating remains high, in spite of mitigating actions, due to the climate of risk of legal challenges concerning compliance with these duties, for example, a JR on both sets of duties was threatened in relation to public health grant reductions but withdrawn in June 2015 following strong resistance from DH lawyers and the BMA recently cited the public sector equality duty as part of the ongoing dispute around junior doctors' terms and conditions. DH lawyers are resisting this challenge.
2) An additional risk for health inequalities is the **failure to achieve the SDP objective of measurable and sustained reductions in health inequalities**. Health inequalities are reflected in chapters 5 (prevention) and 7 as part of a cross-cutting theme on enabling people and communities to make decisions about their own health and care. Reducing health inequalities will also be vital in achieving several SDP objectives such as obesity, diabetes and reducing the mortality gap for people with mental health problems. Failure to achieve measurable and sustained reductions in health inequalities would result in widening health inequalities and social injustice, increasing the burden on the NHS and social care services and risking reputational damage to the Department as system steward.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. As the SDP is a key driver for achieving a reduction in health inequalities we continue to work to ensure health inequalities are better reflected across the internal SDP.	Name Redacted	Ongoing	Name Redacted has written to all DH Directors to seek appropriate coverage of health inequalities across the internal SDP. The health inequalities team met with Adam McMordie, from the strategic planning unit, on 3 March to discuss how health inequalities can be effectively reflected across the SDP.
2. We continue work on our agreed approach between DH, NHS England and PHE equity and technical teams on strengthening our use of metrics and evidence to support the commitments as set out in the SDP and other key strategic documents, to achieve measurable and sustained reductions in health inequalities. In addition this will provide understanding and knowledge of key actions and interventions supporting both policy making and implementation.		Q1 2016-17	We had our third metrics meeting with NHS England and PHE equity teams on 2 March with the next one scheduled for 12 April. We are currently liaising across DH to resolve a technical issue with HSCIC data production supporting NHS Outcomes Framework inequalities indicators. We met Keith Derbyshire, Deputy Chief Analyst, on 17 March to agree some practical solutions.
3. In September 2015 we conducted a random staff survey to learn about levels of staff awareness of health inequalities legal duties and training needs.		Ongoing	In response to the survey results which showed varying but generally low levels of awareness, we have developed a policy certificate module to fulfil training needs. We plan to repeat the staff survey during Autumn 2016 to assess if levels of awareness have improved and if training needs have changed.
4. In light of the internal audit and staff survey findings (awareness of the legal duties is inconsistent), we run a Policy		Ongoing	We last ran a (fully booked) policy certificate module on 3 March. Previous sessions

Certificate Module 'An introduction to equality and health inequalities' to raise awareness of the legal duties across the Department, and build capability to help ensure both equalities and health inequalities are reflected throughout policy work.			have been well evaluated and there continues to be strong demand. In 2016/17, subject to resources, we will strengthen roll out of the module, in line with the development needs identified in our staff survey.
5. On February 23 2016, Secretary of State wrote to system leaders setting out criteria for 2015-16 to 2020 on which he will assess his own and NHS England's fulfilment of their health inequalities legal duties. The letter emphasised the need to address health inequalities in delivering the SDP, FYFV and other strategic documents across the period to 2020.	Name Redacted	Ongoing	Jon Rouse has written to fellow DGs to draw their attention to the Secretary of State's letter and their own roles in fulfilling the health inequalities legal duties in their Directorates. This will help to raise the profile of the health inequalities legal duties throughout the Department and highlight the shared responsibility for delivering the SDP commitment to achieve measureable reductions in health inequalities. Next module provisionally scheduled for June.
6. We continue to work reactively with policy teams to ensure that they can demonstrate compliance with both equality and health inequalities duties. An increased awareness of the legal duties throughout the Department will ensure health inequalities are more thoroughly reflected in delivery of SDP commitments.		Ongoing	We will work with colleagues leading on SDP work streams where the need to tackle health inequalities has been made explicit, e.g. prevention, obesity, diabetes and cancer, as well as continue to highlight overall corporate responsibilities including through internal communications channels such as DH Life and Yammer.
7. We are helping to ensure the robust operation of director-led equality assurance arrangements including the regular collection of information from policy leads via DLALs.		Ongoing	Jon Rouse wrote to DLALs on 11th February asking them to improve the quality of information on the rolling register. We will continue to sense check information to ensure it's meaningful and fit for external publication where appropriate. A further internal audit of the assurance arrangements has taken place in March. We will seek to strengthen those arrangements in light of the audit recommendations.
8. We have met the Department's duty to publish equality information covering 2015. Relationships with the statutory regulator remain positive, as a result of pro-active relationship management.		31 Jan 2016	This was published on gov.uk on 29th January completed. The first quarterly meeting with the Equality and Human Rights Commission took place on 29th March, with others scheduled for 23rd June, 26th September and 1st December.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)
In March 2015, an internal audit of the Department's readiness in regard to implementing and ensuring DH compliance with the Secretary of State's health inequalities legal duties made four recommendations for strengthening assurance arrangements and raising awareness and understanding of the duties. All recommendations were met in full ahead of schedule and signed off by auditors in January 2016.



10. Obesity – revised wording following proposal to manage diabetes and obesity risks separately

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
PIHD	Felicity Harvey	January 2016	22.04.16	Operational

Risk Description:

Risk: The Government's strategy on childhood obesity is not delivered leading to significant increased costs of obesity-related ill health.
Cause(s): The UK has one of the worst records for childhood obesity amongst developed countries with 1 in 10 obese at age 4, and 2 in 10 obese by age 11. This risk is caused by a number of inter-related factors, including, but not limited to: 1) awareness of healthy eating and physical exercise, 2) availability and advertising of low cost, unhealthy food, 3) levels of physical exercise, 4) failure to take action in early years, 5) the limited action on obesity by families and schools.
Impact(s): Significant effects to longer term health in Britain which are costly both in terms of need for health services and have a debilitating effect on the economy through ability to participate in work and cost of benefits.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	3	Impact	5	RED	3/5 RED	Likelihood	1	Impact	5	AMBER	1/5 AMBER	↔	Likelihood	1	Impact	3	AMBER/GREEN

Background

The UK has one of the worst records for childhood obesity in the developed world. Nearly a third of children aged 2-15 are overweight or obese. We know that obese children are much more likely to become obese adults. The Childhood Obesity strategy is the significant mitigating action against this risk as tackling obesity in children will have a significant preventative effect on adult ill health that is obesity related.

The economic costs are great as it was estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15 which means we spend more every year on the treatment of obesity and diabetes than we do on the police, fire service and judicial system combined. Unchecked, it will lead to significant costs to the health and care system, as a result of increased incidence of ill health (e.g. diabetes, cancer, cardio-vascular disease); and the effects on the economy, through lost productivity and increased welfare benefits will be similarly increased.

The role of DH is to set and coordinate the strategic direction for government on childhood obesity and to ensure that the strategy is delivered.

There is an underpinning risk that the Childhood Obesity Strategy (COS) programme does not have the desired impact on reducing the national threat obesity presents to the UK as set out in the Secretary of State ambition to significantly reduce childhood obesity in its delivery, and consequently, fails to deliver a big manifesto commitment causing substantial reputational damage. There are a number of issues here such as lack of resources (e.g. investment by NHS), ministerial disengagement, disengagement and failure to deliver elements of the strategy by OGDs, and/or the strategy does not utilise sufficient levers to have sufficient impact on the obesogenic environment.

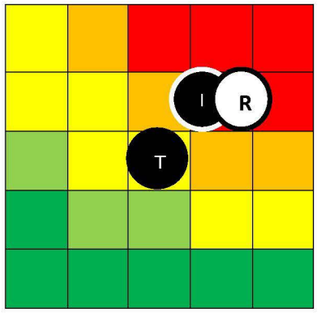
Ministerial engagement continues to focus on Obesity to secure policies and ensure the launch of the Childhood Obesity Strategy, which is likely to be published in the summer. Work is ongoing to refine the strategy, incorporating an addition which is specific to adult obesity and governance architecture around implementation of the strategy is underway. However, the recent soft drinks industry levy, announced in the Budget, signalled a real intent to tackle the issue.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Policy leads drafting a letter for PM from Secretary of State which will outline the case for and scope of interventions.	Mark Davies/ Emma Reed	February 2016	Complete
2. Longer term savings to be scoped.	Mark Davies/ Emma Reed	Pending / Summer 2016	Quality Assurance is taking place re: £0.48bn identified savings through prevention alone and further scoping may take place. Initial scoping on some elements, but more work after publication – Summer 2016.
3. Publishing the childhood Obesity Strategy -	Emma Reed	Summer 2016	The content of the Childhood Obesity Strategy is not yet agreed and is awaiting PM steer/approval before it can seek HAC clearance, but the scheduled date of announcements is likely to take place in the summer. Although the strategy is not yet signed off the categories of mitigation expected are based around: 1) altering the food environment 2) taking action in schools 3) through the delivery of public services 4) increasing levels of physical activity 5) The Diabetes Prevention Programme will mitigate some of the

			major health risks associated with obesity At present there are 48 mitigating actions but this could change when the final strategy is agreed. 1. Agree Communications Strategy and discussion on received PM steers. 2. PHE's "One You" programme will seek to influence the health behaviour of the 40-60 year-old age group, and so will help to address obesity and some of its health harms 3. Work is underway to scope delivery activity between now and publication, and beyond publication. This will include stakeholder and communications management.
4. Implementation and tracking of the Childhood Obesity Strategy -		Post summer 2016 publication	We are putting in place/exploring ways to track progress and benefits to ensure delivery once the strategy is agreed.
5. Identifying and funding resource requirements	Emma Reed	June 2016 – within SR settlement and early work depends on Strategy content	There is a risk that the programme is unable to demonstrate sufficient return on investment to justify the upfront funding required through the SR and then, in particular, unable to secure sufficient funding for key stakeholders to deliver the programme and to cover the upfront costs of the programme. Programme management and robust planning put in place to identify resource requirements and realistic timescales for delivery. Liaison with legal team to make them aware of our resource requirements. Final details of SR are yet to be announced but work is ongoing to assess the impact on the delivery of the strategy. Engagement with key stakeholders is ongoing, specifically PHE with regards to their Change4Life programme, which has received significantly lower funding than requested.
6. We will be developing stakeholder engagement plans which will: (a) take account of potential negative reactions from for example NGOs, the general public and stakeholders and manage communications and publications to increase engagement with interventions.	Emma Reed	Being developed and refined before publication June 2016	Work continues with communications work stream to develop communications strategy in light of recent delays in COS publication. Obesity polling shows a strong support for child obesity measures and recent work has developed the Diabetes strand of the communications strategy. The delays in publication of the COS mean this risk is still high with a focus in the media on childhood obesity. On 16 March the Chancellor announced plans for the introduction of a sugar levy which will become operational in 2018. This announcement was welcomed by public health organisations, and had significant Parliamentary and public support. The levy aims to support the wider sugar reduction work led by PHE. In early May HMT will consult on the details of the policy with the soft drinks industry, who understandably have concerns. Final strategy content and launch is still subject to No10 grid slot and HA Clearance.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



11. Adult Social Care System Failure

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
SCLGCP	Jon Rouse	July 2015	24.03.16	Operational

Risk Description:

Risk: Financial position of local government, and fragility of ASC market and workforce, leads to systemic or individual failings in ASC services, and broader failure of Government to realise benefits of Care Act
Cause(s): (1) SR Settlement (2) LAs driving savings from provider fee rates (3) LAs prioritising funding away from social care to other local government services (4) providers exiting the market,
Impact(s): (1) Rising unmet need and declining quality (2) Care Act benefits not realised (3) Possibility DH/DCLG intervention in LA required (4) Increased pressure on NHS (5) NHS pull back from further integration and risks to success of devolution deals, (6) Increased number of providers exit market and lack of new investment in services for those funded by the state (7) Reduced number of people receiving publicly funded ASC (8) Decline in outcome measures (9) Increased pressures on carers and the voluntary sector (10) Workforce shortages and lack of long term capacity planning for sector (11) Reduced resilience for sector to manage major incidents.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	4	RED	4/5 RED	Likelihood	4	Impact	4	RED	3/5 RED	↔	Likelihood	3	Impact	3	AMBER

Background

The Adult Social Care SR settlement gives real terms growth across the parliament, with an additional £3.5bn in 19/20 from a direct grant (via the Better Care Fund) and the ability of councils to raise their council tax by 2% pa (the Social Care Precept). The CCG contribution via the BCF will also increase in real terms. The first two years are extremely challenging. Set against significant reductions in ASC budgets over the previous SR, the need for further reductions leads to significant delivery risks. The overall position for local authorities, and therefore context for social care, is that spending power will reduce by 1.7% pa or 6.7% by 2019/20; that centrally allocated budgets will be largely phased out in this period; that full Business Rates Retention will be in place from 2020; and there will be a growing number of devolution deals. Adult social care budget represents ~ 42% of a Council's total budget. The estimated gap in funding for adult social care, taking account of demographic and other cost pressures is between £1 - 1.6bn in 2016/17, growing to £1.1 - 1.9bn in 2019/20. There are very significant regional and sub-regional variations in the positions of Local Authorities and social care providers.

These pressures are likely to manifest in a range of different ways:

- **Quality and Prevention** - it will be challenging for the system to maintain quality, and there may be rising unmet need, reductions in the number of people receiving state support, and disinvestment in prevention and early interventions.
- **Care Act and Outcomes** - the anticipated benefits of the Care Act 2014 are less likely to be realised. Adult social care outcomes may decline (which will be apparent in ASCOF measures)
- **Care markets -** an increasing number of care providers are likely to exit the state funded market either through insolvency, or re-focussing their businesses to concentrate on the profitable self-funder market. This is due to reduced access to credit, poor CQC quality ratings and low fees paid by LAs. As a result, increasing numbers of local authorities and CCG's are increasingly finding themselves with a diminishing pool of providers willing to do business at an affordable rate.
- **Workforce** - it is likely to become increasingly difficult for the sector to attract and retain workforce, which is causing significant capacity constraints in domiciliary care, social care nursing and registered care home managers. While the National Living Wage will be welcome for individual workers its introduction will increase costs to providers and pressure on fees without necessarily attracting more workers into the sector.
- **Impact on NHS** - social care capacity is also a significant contributing factor to the rise in Delayed Transfer of Care, which is affecting the performance of the NHS. Delays caused by lack of home care capacity have risen very sharply over the course of this year. Rising unmet need and reduced service user numbers are also likely to lead to increase in avoidable admissions
- **Integration and devolution** - the appetite for integration from the NHS may decline if local health partners believe that closer joint arrangements with local authorities add to their financial risk. The financial position of councils also risks delivery of ambitions around health and social care integration in devolution deals.
- **Emergency preparedness** – the capacity of the sector to respond to major incidents may reduce and the resilience and flexibility of the sector is becoming more constrained.
- **Carers and the voluntary sector -** increased pressures are likely to be placed on carers and the voluntary sector. This may lead to reduced participation in the workforce, impacting overall performance of the economy
- **Capacity of sector to improve** –a model of sector led improvement has proven to be effective in driving improvement and tackling poor performance, which has also avoided creating a costly national improvement support infrastructure. However, this relies on willing volunteers giving up time to support sector networks, and we risk this support mechanism reducing or being too small to cope with the scale of the issues facing adult social care.

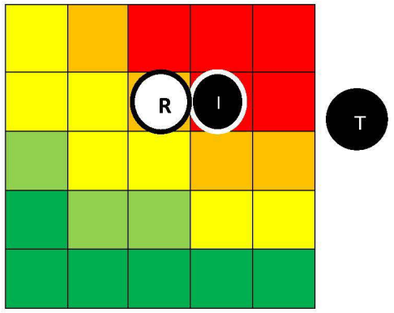
Response plan (further activities):

Activity	Action Owner	Due date	Action update
Increase monitoring of the local authorities and the market through further development of our resilience intelligence tool, supported by analytical work to better understand risks across the system and close engagement with key partner organisations. This work to include specific work on financial risk, working with DCLG. On the basis of this intelligence, we will work with DCLG and the sector on potential interventions.	**Name Redacted** LA oversight) Tabitha Jay (finance)	1. May 2016 2. Meets bi-monthly 3. March 2016	1. Held Permanent Secretaries meeting between DH, DCLG and DfE to discuss approach to local government oversight; agreed that departments will work together on oversight, support models and analysis, including shared set of metrics with further meeting due for May 2016. 2. Social Care Oversight Group to monitor risks and actions 3. DCLG have now published the level of Council Tax set by local authorities in England for the financial year 2016 to 2017. 144 out 152 adult social care authorities (approx. 95%) will utilise all or some of the 2% precept when setting their

			council tax. This will raise £382 million in 2016/17.
Monitor Care Act benefit realisation and system risk as per benefits realisation plan including via sector intelligence from Social Care Steering Group and reporting to Social Care Oversight Group	Tabitha Brufal	1. Feb 2016 2. April 2016 3. Jun 2016	1. MPA closedown review completed 2. Confirm benefits realisation plan and new governance and business as usual arrangements following close down of programme 3. Plan review of first year of Care Act implementation
Contingency planning is in place (and being further developed) to cover both a major failure in the social care market (with CQC) and different emergency situations such as pandemic flu or flooding (with EPPR directorate).	Tabitha Brufal (Markets) **Name Redacted** (Emergency Preparedness)	1. Jun 2016 2. Ongoing review 3. Sept 2016	1. Scenario planning workshop held with CQC in Dec, repeated with other government departments and local government. Agreed to develop protocol by Spring 2016, and run quarterly programme of table-top exercises to consider scenarios in more detail 2. Protocols agreed with DCLG to share intelligence and agree actions (via LRFs) during major incidents 3. Exercise Cygnus rescheduled for October, will have a social care 'inject'. Preparatory work in the interim with participating LAs will also develop planning for severe scenarios; report to Sept SCOG.
Support the financial sustainability of the sector, by: • taking measures to increase revenues from social care charges; • protecting social care funding from encroachment from other local services • seeking to deliver efficiencies by best practice sharing and red tape reduction.	Tabitha Jay (efficiency) Paul Richardson (bureaucracy)	1. Feb 2016 (delayed) 2. Feb 2016 3. May 2016 4. Ongoing 5. Launch Feb 2016 6. July 2016	1. HA clearance refused for reducing disregard period; awaiting clearance on savings through freezing allowances. 2. Social care precept conditions being finalised by DCLG. Work commenced on CQC inspections of commissioning & local scorecards. - Completed 3. Respond to Funded Nursing Care Review report 4. Scope efficiency work including advise to Secretary of State 5. Launch project to reduce bureaucratic burdens on the provider sector [subject to No10 grid slot]. – Completed 6. 2016/17 LA budget published. Review of how precept applied with DCLG. Sanctions to be considered.
Increase supply-side interventions to support a sustainable market and attract and retain social care workers. This includes a specific programme on the social care market.	Tabitha Brufal (Markets) Paul Richardson (Workforce)	1. By April 2016	1. State of the market pack presented to Jeremy Heywood and welcomed. Now establishing work plan, resources and governance.
Fund a support programme for sector, working with the LGA, ADASS, Skills for Care, Social Care Institute of Excellence and others, to provide a coherent and well-targeted package of support.	**Name Redacted** and Paul Richardson	1. June 2016 2. June 2016	1. Review funding to all external bodies to ensure a coherent and prioritised, offer to the sector. 16/17 to be a transitional year to 17/18. Confirmation of Q1 programme given to LGA to provide continuity. 2. Design programme to address high value actions and risks, including efficiency, markets, delivery and integration.
Develop cost-neutral policy to support individuals and carers who need social care, including a Carers' Strategy, and working with the Tripartite on how best to integrate services and improve discharge processes.	Tabitha Brufal (Social Care Policy) Ed Scully (Integration)	1. Feb 2016 (delayed) 2. May 2016 3. Next meeting April	1. Change of approach to Carers Strategy agreed; Secretary of State to give steer on further analysis to underpin and MS(CS) to launch call for evidence 2. Working with CO, HMT, DCLG and NHSE to agree parameters for SR commitment to integration by 2020. 3. New Discharge Programme board established with NHS England, ADASS, LGA, NHS Improvement, DH and DCLG; agreeing common narrative and work programme, working to define support programme on local systems and drive progress on solving key barriers to good discharge.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)
DH works very closely with CLG on local government finance and related issues.

12. Financial sustainability of the health and care system



Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
FC&NHS	David Williams	Pre 2013 (re-drafted Dec 2015)	31.03.16	Operational

Risk Description:

Risk: Failure to deliver a sustainable health and care system while maintaining key financial targets. (Adult social care sustainability care dealt with in risk 11)
Cause(s): (1) Targets are unrealistic and unachievable, (2) Unforeseen additional demand
Impact(s): (1) Unaffordable health and care system, (2) Reduction in the quality and access to care, (3) Diverted focus from FYFV implementation

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	4	RED	RED 4/4	Likelihood	3	Impact	4	AMBER/RED	AMBER/RED 3/4	↔	Likelihood	tbc	Impact	tbc	tbc

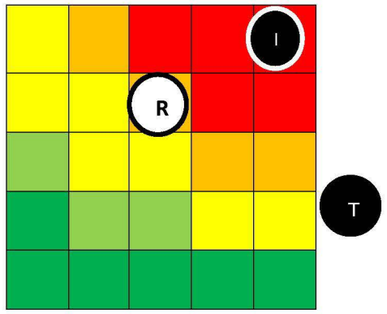
Background:

Significant work is ongoing to plan and implement savings to meet the efficiency challenge identified by the FYFV and following the Spending Review. Progress is being driven through weekly Secretary of State meetings, also including external challenge from Jeremy Heywood, Oliver Letwin and Nick Seddon. Delivery and political risks, and actions and timelines required for implementation are being made clear, to ensure that all possible areas for savings are explored and tested with Ministers, with as full information as possible.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Establish governance across DH and ALBs for the efficiency savings programme through the Finance and Efficiency Board and introducing a new Programme Challenge Group chaired by David Williams.	Name Redacted (NHS Efficiency)	End Jan 2016	Action 1 - First Programme Challenge Group meetings scheduled for April
2. Further develop and refine efficiency savings plan to ensure it matches the savings required by the SR settlement	(NHS Efficiency)	End Jan 2016	
3. Identify possible areas of duplication and ensure there are key metrics, milestones, governance and interdependencies for each savings area.	(NHS Efficiency)	End March 2016	
4. Increased focus on implementation with regular information collection processes instituted to ensure that there is regular reporting on progress and risks.	(NHS Efficiency)	End Jan 2016	
5. Develop Shared Planning Guidance to include clarity on the ask for commissioners and providers, including setting out the different areas each type of organisation needs to focus on. The aim is that the planning guidance will enable local commissioners and providers to begin planning to close all of the FYFV gaps from next April.	(FYFV programme office)	End of Dec 2015	
6. An engagement and communication strategy to be developed, supplemented by temperature check visits from Lord Prior's office.	Name Redacted (FYFV programme office)	End Jan 2016	

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



13. Performance of the health and care system

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
FC&NHS	David Williams	Pre 2013 (re-drafted Dec 2015)	31..03.16	Operational

Risk Description:

Risk: Failure to achieve and maintain key access targets.
Cause(s): (1) Funding pressures, (2) Unsustainable demand
Impact(s): (1) A reduction in the quality of and access to care, (2) Diverted focus from FYFV implementation

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	5	Impact	5	RED	5/5 RED	Likelihood	3	Impact	4	AMBER/RED	3/4 AMBER/RED	↔	Likelihood	tbc	Impact	tbc	tbc

Background:

Funding Pressures

Agreed plan at start of year shows indicated overspend of £2.1bn as a result of provider deficits

- Deficit limits agreed in Q2 with Monitor and TDA to reduce the net deficit to £1.6bn. However, the plan is now that the target for net deficits is £1.8bn
- Monthly monitoring of all group components and providers assured by relevant oversight body - DH, TDA, Monitor or NHSE
- Additional resources provided, through capital to revenue switch - £185m - and one-off adjustment £300m
- Halt to all non-essential discretionary spending in core DH and additional controls on ALBs - current forecast is to deliver a balanced position across DH, ALBs and NHS England although this relies on a successful reserve claim with HMT to mitigate an emerging central pressure in respect of PPRS income (£150m)
- Remaining gap of c£600m being addressed through NHSE and the DH/ALBs - current plans identified to close c£400m, with a residual gap to close of c£200m

Unsustainable Demand

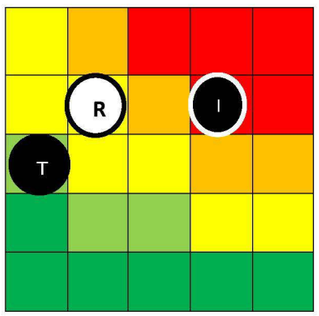
- Extensive and co-ordinated planning across ALBs drawing on lessons from last year and expert identified best practice.
- Internal ALB assurances
- Performance tracking and managing with increasing interventions.
- ALBs with DH developing strategic long term plans to meet performance standards for both elective and non-elective care through 15/16 and 16/17
- Winter money provider earlier than previously and against plans assured by NHSE. Lessons have been learnt from last year and systems have received money earlier to allow effective long term planning
- Use of intensive support teams. Use of ECIST and through winter the ECIP programme will continue to support areas under the most pressure to improve their performance. This is supplemented by work from the DH Implementation Unit.
- Use of independent sector to provide capacity and targeted drive to reduce 18+week waiters to 2010 levels.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
Funding Pressures 1. Further capital/revenue switch of £950m with HMT through additional capital slippage and controls	Andrew Baigent	Agreed	
2. Reserve claim sought at Spring Supps to cover previously unfunded central pressures mainly for PPRS £205m	Andrew Baigent	Agreed	
3. NHSE expected to underspend by c£400m against Mandate (£478m confirmed at M10)	Andrew Baigent	Agreed	
4. "Lockdown" process introduced in respect of central spending to ensure delivery of spending within central envelope	Andrew Baigent	Ongoing	
5. Weekly meetings in place with system leaders to urgently review overall financial position, delivery of identified savings and to identify further savings to close the residual gap	Andrew Baigent	Ongoing	
6. Fortnightly SOS meetings with NHSE/NHSI/DH focussed on 15/16 financial balance	Andrew Baigent	Ongoing	
Unsustainable demand 7. Continual close monitoring of the 55 most at risk health systems over Winter. Including frequent reporting to Ministers and No10 through a comprehensive series of winter products.	Name Redacted	End March 2016	Scoping and planning for the evaluation of winter interventions is underway
8. Co-ordinated winter response from DH and the Tripartite including National and Regional Winter Rooms.		Feb 2016	
9. Focused work on Delayed Discharges and patient flow to relieve blockages in the system and improving performance at the 'front end' i.e. A&E performance and decreased handover delays including ECIP work with challenged trusts to address patient flow issues (social care integrated) and a New DH-led Discharge Programme, with cross-system buy-in and representation on Programme Board.		Ongoing	DH Discharge programme working towards first agreed milestones
10. Weekly Secretary of State Delivery meeting with all Key ALBs to enable constructive discussion. Supplemented and supported by additional official level meetings.		Ongoing	Initial A&E, RTT and Cancer plans from Tripartite agreed with Secretary of State through Delivery process.
11. Regular reporting of progress against performance plans at Secretary of State Priority meetings and continued challenge at official level meetings.		Ongoing	
12. A PMO has been established to use IS capacity to meet capacity shortfalls in NHS providers. A separate PMO has also been established to focus on the		Ongoing	Diagnostic plan has been commissioned for April

backlog for Endoscopy.			2016
13. Sector-led Programme to tackle patient flow in place with local government, including promotion of the high impact change tool and individual level conversations with LAs where DTOC is unacceptably high	Name Redacted		Work ongoing.

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



REQUEST TO REMOVE 14. Workforce Pay – Junior Doctors

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
SER	Charlie Massey	Dec 2015	07.12.15	Tactical

Risk Description:

Risk: DH fails to negotiate successfully with Junior Doctors threatening strike action regarding the proposed changes to their contracts.
Cause(s): (1) Junior Doctors have agreed to ballot for industrial action over proposed contract changes
Impact(s): (1) Risk to front line service delivery if strike action goes ahead, (2) Negotiations may not be able to keep within the required costs envelope.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	4	Impact	4	RED	n/a	Likelihood	2	Impact	4	AMBER	n/a		Likelihood	1	Impact	3	AMBER/GREEN

Background:

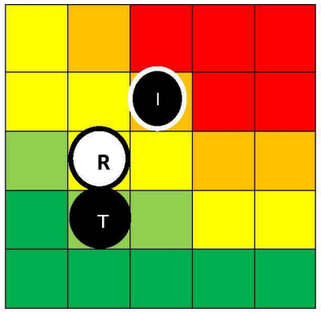
The Government has confirmed public sector pay will be capped at 1% over the next 4 years 2016/17 to 2019/20 with any pay award targeted towards recruitment and retention issues.

Junior doctors voted for industrial action in a ballot conducted by the BMA, and three days of action were announced on 1, 8 and 16 December. Following conciliation by ACAS this action was suspended on 30 November and the Junior Doctors Committee have agreed to enter negotiations, due to begin in week of 7 December. Deadline for agreement is effectively 6 January.

Response plan (further activities):

Activity	Action Owner	Due date	Action update
1. Agenda for negotiations agreed in discussions with ACAS	DH workforce and NHS employers	30 Nov 2015	Negotiations have begun (w/c 7 Dec)
2. Conduct of negotiations aimed at securing deal - early agreement on redlines with HMT and No 10.	DH workforce	14 Dec 2015	

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)



15. (tbc) Implementation of technology programmes – update cleared by Tim Donohoe.

Directorate	Risk Owner	Date risk identified	Date last reviewed	Risk Category
IGT	Tamara Finkelstein	22.01.16	24.04.16	Strategic

Risk Description:

Risk: There is a risk that implementation of Paperless 2020 is delayed and does not meet NHS/ Social Care needs or match patients/service user expectations.
Cause(s): (1) Delay to mobilisation and lack of pace. (2) Lack of capability and capacity to manage and deliver the programmes of work. (3) Insufficient funding to support activity in critical years. (4) Further changes to system governance create instability and introduce delay to delivery and increase the risk to the department. (5) Lack of strategic focus and planning. (6) Insufficient focus on user/system need. (7)Front line organisations unable/slow/unwilling to implement
Impact(s): (1) Fails to deliver key requirements and risk critical business operations on time, affecting organisations, patients and care users; (2) Unable to generate pace across the portfolio and manage dependencies effectively. (3) Reputational damage, lack of confidence in DH and ALBs to manage complex portfolio and drive transformational change. (4) PH&C2020 and FYFV targets are not met. (5) Contributions to £22bn efficiency savings are not met, or slower than expected. (6) Unable to maximise funding allocation from SR.

Inherent/Current Risk					Previous Inherent Risk	Residual Risk RAG (after further actions)					Previous Residual RAG	Trend	Target Risk				
Likelihood	3	Impact	4	AMBER/RED	n/a	Likelihood	2	Impact	3	AMBER	n/a	n/a	Likelihood	2	Impact	2	AMBER/GREEN

Background

- A number of existing informatics technology programmes costing around £1bn are at different stages of development and deployment. They are currently managed through a strategic forum (IPMB and its portfolio office). These programmes range from network infrastructure (e.g. HSCN), services (e.g. SPINE, GPSOC), data (e.g. GPES, care.data), and web services (e.g. eRS, NHS.UK, EPS), all are complex and have differing levels of risk e.g. Critical National Infrastructure (CNI); complex delivery path; new technology, dependency management, ability to realise targeted benefits; commercial complexity (contract exit); affordability and ability to make cash releasing savings.
- The National Information Board (NIB), a collaborative strategic forum across DH and ALBs, has set out it's aspirations for the future of technology services in its Personalised Health and Care 2020 (PHC2020) published in Nov 2104. It stated the strategic intent for Digital technology, which has the power to transform the health and care system by providing citizens with the control and convenience , and improve quality of service whilst at the same time reduce costs.
- A series of road maps were created setting out how this vision would be taken forward over the 5 year period of this parliament and were used to create the revised Paperless 2020 portfolio of technical and digital programmes.
- SR funding of £4.7bn was approved and the Secretary of State agreed the revised Paperless 2020 with DH and its ALBs on 4 April 2016.
- Work continues with the ALBs and HM Treasury to agree the priority of the existing and new programmes going forward.
- Whilst this is very significant and wide ranging, it does not however include ALL informatics technology across ALL ALBs.
- ALB resources; a recent ALBs sponsor assessments exercise has demonstrated a lack of capacity & capability, to varying degrees in the digital area, across ALBs.

Response plan (further activities/mitigations):

Activity	Action Owner	Due date	Action update
1. Establish single portfolio enterprise reporting and planning tool to ensure alignment, tracking of all deliverable and commitments.	Name Redacted	July 2016	In progress
2. Ensure informatics technology programmes are resourced and working to common standards		July 2016	Started
3. Strategic planning and prioritisation of NIB and the current portfolio of programmes – Secretary of State approved priority planning for 10 domains, and 33 programmes of work in early April , accounting for £4.7bn expenditure	Tamara Finkelstein	May 2016	In progress
4. National Informatics governance arrangements are being reviewed to align leadership and accountability (IFOM review) across a range of ALBs and the DH.	Tamara Finkelstein	April 2016	In progress
5. NIB review of appropriate informatics workstreams, and HMT discussions as part of SR	Will Cavendish	November 2015	Complete

Further information (including insight from Comms, Strategy, Implementation Unit and Other Government Departments)