BOARD OF DIRECTORS MEETING (Open)

Date: 8 November 2017 Item Ref: **10**

TITLE OF PAPER	Board Assurance Framework (BAF) 2017-18
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	Discussion and approval.

OUTCOME	To have an agreed BAF which is regularly maintained, monitored and reviewed and provides assurance to the Board that strategic risks are identified and managed.
TIMETABLE FOR DECISION	8 November 2017
LINKS TO OTHER KEY REPORTS/ DECISIONS	Shaping the Future, the Trust Strategy and Strategic Planning Framework 2017 - 2020 Internal Audit Reports covering Board Assurance Framework and Risk Management arrangements Corporate (organisational) risk register, Directorate risk registers NHS Improvement’s regulatory framework and Provider Licence Annual Governance Statement.
BAF OBJECTIVE No and TITLE	BAF links to strategic objectives.
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Implications of individual risks are highlighted in the BAF. The BAF enables the Trust to satisfy its regulatory requirements and provides assurance for the Chief Executive to sign the Annual Governance Statement
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement’s Governance regulations and Provider Licence.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	1 November 2017

SUMMARY REPORT

Report to: Board of Directors

Date: 8 November 2017

Subject: Board Assurance Framework (BAF) 2017/18

From: Margaret Saunders, Director of Corporate Governance (Board Secretary)

Author: Sam Stoddart, Deputy Board Secretary

1 Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
✓					

2 Summary

In March 2017 following a comprehensive CQC Inspection the Trust received a good rating. The Trust now aspires to be outstanding and this paper details a number of corporate governance actions to support this and meet the requirements of:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance

- NHS Improvement - Development reviews of leadership and governance using the well-led framework, https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf requires the Trust to have a board assurance framework (BAF) and risk registers in place which are assessed by the board on a quarterly basis as a minimum.

- Securing an improved Head of Internal Audit for 2016/17 opinion and

- Mitigate strategic objective 'we will improve the productivity and efficiency of our services' and BAF Risk A401ii – Trust Governance systems are not sufficiently embedded.

Board Assurance Framework

Update on Next Steps

The BAF enables the Board to consider the process of securing assurance using a formal process that promotes good organisational governance and accountability.

The Board of Directors received the Board Assurance Framework 2017/18 – Next Steps paper in June 2017 detailing the process undertaken to populate the BAF for 2017-18 https://shsc.nhs.uk/wp-content/uploads/2014/04/08-Open-BoD-June-2017-BAF-2017-18-Next-Steps.pdf. In July 2017, in conjunction with executive directors and risk leads, the first iteration of the 2017/18 BAF was presented to the Audit Committee and Board.

In the intervening period work has continued to populate the Trust's Safeguard Risk Management System's BAF module with the content of the BAF. Bespoke training for nominated Directorate leads and Executive Directors to enable local, dynamic updates and quality assurance of the content of the BAF utilising the Safeguard Risk Management System will take place on Tuesday 14 November 2017.

BAF Summary

The BAF has continued to be updated and refined, with efforts taken to give greater specificity to certain risks. The Board is specifically asked to note that risks A101 and A102 have each been split into two risks each.

The report has all risk actions numbered; non sequential numbering indicates an action has been completed and closed. This is relevant to risks A101 and A102 which were significantly changed from the first iteration, a number of the original actions were changed or removed and replaced with new actions to reflect the restructuring of the risk, future BAF summary will indicate if a risk has been closed with supporting narrative confirming the rationale for closure. Additionally going forward greater emphasis will be placed on content ensuring controls, assurances, gaps and actions are appropriately and sufficiently recorded, Appendices 1 and 2. This will enable analysis of the BAF to determine what this means for the organisation in relation to the management of the high level strategic risks.

Oversight

Each BAF risk is assigned to an executive and relevant Board committee. Oversight of the risk is the responsibility of the committee to be assured from the papers presented that the risk is being adequately controlled, actions undertaken and any additional sources of assurance, controls or actions are recorded on the BAF.

The committees to which risks are assigned along with links to risks on the corporate risk register are detailed in Appendix 3.

3 Next Steps

The BAF and corporate risks will be updated in line with feedback from the Board.

4 Required Actions

The Board is asked to:

a) Note progress of Next Steps

b) Receive and approve the BAF.

5 Monitoring Arrangements

The BAF and Corporate Risk Register is monitored by the Director of Corporate Governance (Board Secretary). However, it is the responsibility of Board Committees to ensure that they have due oversight of those risks for which they have responsibility and that the papers which are brought before them provide sufficient assurance that risks are being addressed and managed.

6 Contact Details

For further information, please contact:
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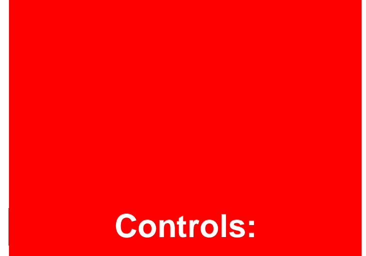
Definitions

Appendix 1



Controls:	The many different things that are in place to mitigate risk and assist in the delivery of security objectives. They should make a risk less likely to happen or reduce its effect if it does. The Chartered Institute of Internal Auditors defines a control as "any action taken by management, the board and other parties to manage risk and increase the likelihood that established objectives and goals will be achieved. Management plans, organises and directs the performance of sufficient actions to provide reasonable assurance that objectives and goals will be achieved." The Board should consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
Assurance:	Evidence obtained from a variety of sources including management reports, minutes, internal and external audit reports that controls are operating effectively, routinely applied and the underlying objective will be achieved.
Gap in control:	This exists where adequate controls are not in place or where collectively they are not sufficiently effective.
Gap in assurance:	This exists where there is a failure to gain evidence that the controls are effective.
Actions:	Wherever gaps in control or assurance are identified, action plans must be in place and allocated to executives to ensure the situation is remedied.

Reference: A Simple Rules Guide for the NHS: Board Assurance Frameworks, Good Governance Institute 2009

Reference: Chartered Institute of Internal Auditors https://www.iia.org.uk/resources/control/

Assurance Ratings

Appendix 2

Rating	Description
Full Assurance	The system of internal control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant Assurance	There is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate Assurance	There is a sound system of internal control. However, inconsistent application of controls put the achievement of the organisation's objectives at risk.
Limited Assurance	Weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.
No Assurance	Weaknesses in control, or consistent non-compliance with key controls could result (have resulted) in failure to achieve the organisation's objectives in the areas reviewed.

Reference: 360 Assurance

Appendix 3

Links between Board Assurance Framework, Corporate Risk Register and Board Committees 2017/18

BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee(s)
A101i	Inability to provide high quality care due to failure to meet regulatory standards (registration & compliance).	3322 3679 3788	QAC QAC QAC
A101ii	Inability to provide assurance regarding improvements in the quality of patient care.	3322 3831	QAC QAC
A102i	Failure to deliver safe care due to insufficient numbers of appropriately trained staff.	3768	WODC
A102ii	Inability to provide assurance regarding improvement in the safety of patient care.	3322	QAC
		3679	QAC
A103	Failure to comprehensively capture the experience of our service users and take appropriate action		QAC
A104i	Failure to achieve national performance targets for IAPT and EIS.		QAC
A104ii	Lack of ability to influence our commissioners' intentions	3842	QAC
A201	An inability to redeploy staff as a result of organisational change		WODC
A202	A failure to develop a sustainable and integrated workforce strategy including a clear understanding of our current and future workforce requirements and how we work effectively with partners to deliver the strategy.		WODC
A203	Risk of disconnect between Trust values and operational delivery plus reputational risk from poor management practice	2231	WODC
A204	Risk of low motivation and morale compromises staff motivation		WODC
A301	Lack of primary care strategy		BoD
A302	Lack of Trust framework and a lack of understanding of the Trust's model for collaborative working		BoD
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration	3322	QAC

BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee(s)
A304	There is a lack of community provision in place as an alternative to inpatient care		QAC
A401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes	2175	FIC
		3718	FIC
A401ii	Trust governance systems are not sufficiently embedded		AC
A402	There is a lack of a public health-driven commissioning strategy		BoD
A403	Interdependencies of reconfiguration of community and inpatient restructure are not aligned with the estate plan and associated funding	2175	FIC
A404	There is a lack of embeddedness of digital strategy and interdependencies with associated strategies	3659	QAC

Key:

BoD	Board of Directors
QAC	Quality Assurance Committee
FIC	Finance Investment Committee
AC	Audit Committee
WODC	Workforce and Organisation Development Committee

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.1 Effective Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A101I v.1 Executive Lead: Executive Director - Nursing,
Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance).

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	2	6
Target Risk (after improved controls):	3	1	3

Reviews	
Last Review:	23/10/2017
Next Review:	22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
An Executive-led Care Standards & Quality Assurance Team (CS&QAT) is in place.	The Director is part time & interim. The manager is part time and interim. The administrator post is an unfunded cost pressure.	Funding for Director post only in budget (Apr 17).			Moderate
Outcomes of CQC Well Led Inspection (2016) and Comprehensive Inspection (2017). Clinical Services are fully engaged to address Regulatory Breaches & 'Shoulds'. Bespoke Care Standard Peer Inspections (CSPIs) undertaken by the CS&QAT & Head of Mental Health Legislation (for evidence & Quality Assurance). Exec-led "Task & Finish Oversight Group" ensures progress & delivery of action plans.	Safe Domain rating = 'Requires Improvement' (RI). Three Clinical Services (Hospital) are rated RI: 1. Rehab Wards & CERT. 2. Crisis Services & Health-Based Place of Safety. 3. The Clover Group (General Practice). Adult Social Care Wainwright Crescent is RI.	Exec-led "Task & Finish Oversight Group" reports to: TMG QAC (Sept & Dec '17) and Board (Oct & Jan ' 18). .	CQC Comprehensive Inspection Nov 16 overall rating 'Good'. Quarterly CQC Engagement meetings (Feb, May, Aug 17). Monthly CQC Relationship Meetings (July, Sept 17). Clover Group CQC Announced Inspection 25th Sept '17. CQC Unannounced Inspection of Wainwright Crescent 12th Sept '17.		Moderate
Head of Mental Health Legislation in post (Jan '17). Monthly Mental Health Act Committee (MHAC).	MHA revised governance structure not yet fully implemented. CSPI of MHA of Ward, Team & Directorate Governance meetings not yet taken place.	Monthly & Quarterly MHAC Reports. Weekly Ward and monthly Community Outcomes of	CQC MHA Monitoring Visit Reports (Jul, Aug, Sept 17). CQC Appreciative Inquiry (AI) Visit Report (Jun 17).	Full delivery of the AI Development Plan. Evidence of performance management of the MHA &	Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.1 Effective Quality Assurance And Improvement Will Underpin All We Do.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Revised MHA governance structure. Identification, Monitoring & Reporting System in place for compliance with the MHA. MHA Audit Compliance Programme in place. MHA Annual Work Plan. Planned CSPI of MHA of ward, team and directorate governance meetings.		Compliance Audits. MHA Audit Compliance Programme. MHA revised governance structure proposal approved by EDG and QAC March 17.	Internal Audit (360 Assure) MH Legislation Governance Review & MCA Audit, ToRs agreed (Aug 17).	MCA at Ward, Team & Directorate SMT level via routine recording at governance meetings.	
Mental Capacity Act: Service Director is operational lead. Head of Mental Health Legislation in post. MCA revised governance structure. MCA Audit Compliance Programme in development. Monthly MCA Steering Group. Quarterly MCA Practice Development Group. MCA Annual Work Plan.	Revised governance structure not yet in place. MCA Audit Compliance Programme yet to be delivered.	Output from MCA Practice Development Group fed into MCA Steering Group. MCA Annual Work Plan overseen by MCA Steering Group. Monthly MCA Steering Group Minutes to EDG & QAC.	Internal Audit Reports = limited assurance (Mar 16 & May 17). CQC Inspection (Mar 17).	Full governance and reporting system not yet in place.	Limited
CSPI: Trust currently has a small scale & limited arrangement for	An appropriately resourced CSPI & Quality Assurance function is required (to enable	Current interim CS&QAT Team.	CQC Inspection overall rating 'Good' (Mar 17).		Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.1 Effective Quality Assurance And Improvement Will Underpin All We Do.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
CSPIs & quality assurance.	services to be assessed against all CQC Key Lines of Enquiry (KLOE), work towards RCP Accreditation, learn from others & to achieve 'Outstanding'.				
CS&QAT attend the Clover Group SMT.		Clover Group action plans & progress reports to EDG (Aug 17), QAC (Sept 17) & Board (Oct'17)			Moderate

Action No: 2	Responsible Person: Liz Lightbown	Target Date: 31/01/2018
Action Details	**Action Progress**	
Recruit to a substantive Head of Care Standards & Quality Assurance post.		

Action No: 4	Responsible Person: Liz Lightbown	Target Date: 31/01/2018
Action Details	**Action Progress**	
New Director of Quality to review admin requirements.		

Action No: 9	Responsible Person: Liz Lightbown	Target Date: 31/01/2018
Action Details	**Action Progress**	
Recruit to a (joint) substantive Director of Quality post.	Post advertised October 2017. Shortlisting complete. Interviews taking place 15th November 2017.	

Action No: 10	Responsible Person: Liz Lightbown	Target Date: 29/12/2017
Action Details	**Action Progress**	
The regulatory breaches (Musts) and 'shoulds' are to be completed by the end of Nov 17. Exceptions = major estates works up to 2020/21.		

Action No: 11	Responsible Person: Liz Lightbown	Target Date: 31/01/2018

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY. Strategic 1.1 Effective Quality Assurance And Improvement Will Underpin All We Do.

Action Details	Action Progress
A joint development plan has been produced with City Council, Sheffield Children's Hospital NHS FT and Sheffield CCG.	

Action No: 13 Responsible Person: Liz Lightbown Target Date: 29/12/2017

Action Details	Action Progress
MHA CSPI's to be undertaken.	

Action No: 14 Responsible Person: Liz Lightbown Target Date: 31/01/2018

Action Details	Action Progress
Actions from previous IA reports to be completed.	

Action No: 15 Responsible Person: Liz Lightbown Target Date: 29/12/2017

Action Details	Action Progress
Business case to Business Planning Group Oct/Nov 17 for Care Standards Peer Inspection function.	

Action No: 17 Responsible Person: Anne Cook Target Date: 29/12/2017

Action Details	Action Progress
Internal Audit (360 Assure) to review MH legislations's governance arrangements and aspects of the MCA.	Terms of Reference for the Audit agreed September 2017. 1st meeting took place early October 2017. Date of audit report completion not yet advised but potentially going to Jan 18 Audit Committee.

Action No: 18 Responsible Person: Liz Lightbown Target Date: 30/03/2018

Action Details	Action Progress
Identification, monitoring & reporting system being implemented.	

Action No: 19 Responsible Person: Liz Lightbown Target Date: 30/03/2018

Action Details	Action Progress
MCA CSPIs to be undertaken.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.1 Effective Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A101II v.1 Executive Lead: Medical Director	Risk Rating:	Impact	Likelihood	Score	Reviews	
Inability to provide assurance regarding improvement in the quality of patient care.	Residual Risk (with current controls):	3	2	6	Last Review:	30/10/2017
	Target Risk (after improved controls):	3	1	3	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Implementation of Quality Improvement and Assurance (QI&A) strategy.	Strategy not fully implemented.	Progress reports on QI&A strategy implementation to QAC (bi-annual). This includes updates on the impact of Microsystems. Quarterly Clinical Effectiveness Group assurance reports to QAC.			Moderate
Quality schedule in place as part of national contract with NHS CCG.		Quarterly Impact Assessment (QIA) assurance reports to QAC. All CIP QIAs considered by EDG.	Quality Schedule progress reports from the CCG. Quality is monitored by CCG via quarterly Quality Performance Reviews. Any issues are escalated to the monthly Contract Monitoring Group.		Moderate

Action No: 1	Responsible Person: Mike Hunter	Target Date: 30/03/2018

Action Details	Action Progress
QI&A strategy action plan in place and to be fully implemented.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.2 Deliver Safe Care At All Times.

Risk Ref: A102I v.1 Executive Lead: Executive Director - Nursing,	Risk Rating:	Impact	Likelihood	Score	Reviews	
Failure to deliver safe care due to insufficient numbers of appropriately trained staff.	Residual Risk (with current controls):	4	2	8	Last Review:	23/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Monthly Safer Staffing Group overseen by the Executive Director of Nursing (DoN) & chaired by the Deputy Chief Nurse. Monthly review & analysis of Safer Staffing Data (& action) by DoN & Deputy Chief Nurse. Ward managers and senior nurses manage ward staffing levels on a daily basis. Senior nurse-led bed management and staff redeployment system in place.	Demand for Registered Nurse (RN) posts is greater than available supply = RN Vacancies No Monthly Vacancy Factor Report by Ward & Team. No Up to date RN Workforce Profile. No RN Workforce Modelling & Delivery plan (including ACP & Apprenticeships Business Cases).	Monthly Safer Staffing Reports to EDG & BoD. Daily and weekly bed management & staff redeployment reports.	Internal Audit Report on Safer Staffing = 'Significant Assurance' (Feb 17). NHSI Retention Data Pack (Sept 17).		Moderate
A new E-Rostering System (Allocate) has been purchased & is operational. Allocate Health Roster Module is operational. Allocate Safe Care Module training delivered, being implemented & tested.	Not all RNs are competent using the Allocate E-rostering system. Inconsistent application of E-rostering rules across Wards. Full functionality of the E-rostering system yet to be realised.	Monthly E-Rostering Group reports to Effective Staffing Group. Monthly Safer Staffing Group reports to EDG & BoD.	NHSI Good Rostering Guidance (Jul 16). NQB Safer Staffing Guidance (Jul 16).	Benchmarking NHSI Good Rostering Guidance to be completed.	Limited
Executive and Board lead for E-Rostering is the Director of HR.	No specific E-Rostering report to Board.	E-Rostering Group reports to Effective Staffing Group which reports to WODC.			Limited

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY. | Strategic | 1.2 Deliver Safe Care At All Times.

Action No: 1 | Responsible Person: Liz Lightbown | Target Date: 29/12/2017

Action Details	Action Progress
Deputy Director of Nursing Workforce appointed (interim and part time to Oct 17).	Shortlisting for substantive role taking place on 24/10/17. Interview taking place in November. Therefore, interim post will be extended to accommodate the lead in time for the successful candidate. This is currently being estimated at 31/12/17 depending on whether the successful candidate is internal or external.

Action No: 5 | Responsible Person: Liz Lightbown | Target Date: 30/03/2018

Action Details	Action Progress
A strategic trust-wide recruitment programme commenced in July 2017 and is ongoing and will be reviewed for its effectiveness.	

Action No: 6 | Responsible Person: Liz Lightbown | Target Date: 29/12/2017

Action Details	Action Progress
Detailed RN Workforce Delivery Plan required.	

Action No: 7 | Responsible Person: Dean Wilson | Target Date: 29/12/2017

Action Details	Action Progress
NHS I Benchmarking to be completed.	

Action No: 8 | Responsible Person: Dean Wilson | Target Date: 10/01/2018

Action Details	Action Progress
HR Director to have full oversight, sign off and produce a report to Board on the progress and status of E-Rostering. E-Rostering group next reporting to Effective Staffing Group in December 2017. Following this a report will be produced for January 2018 Board.	

Action No: 9 | Responsible Person: Liz Lightbown | Target Date: 30/11/2017

Action Details	Action Progress
DoN to sign off 'rules' from a clinical perspective with immediate effect.	Not yet completed. Now looking to link this to effective staffing, therefore the timetable has been extended to 30/11/17 to take this into account.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.2 Deliver Safe Care At All Times.

Risk Ref: A102II v.1 Executive Lead: Medical Director	Risk Rating:	Impact	Likelihood	Score	Reviews	
Inability to provide assurance regarding improvement in the safety of patient care.	Residual Risk (with current controls):	4	2	8	Last Review:	30/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Patient Safety Improvement Plan developed and approved by BoD June 17.	Patient Safety Improvement Plan not yet fully implemented.	Progress of implementation plan reported to QAC quarterly.	CQC inspection report (March 17).	CQC rating of 'requires improvement' for patient safety.	Limited
Service User Safety Group monitors patient safety.		Quarterly assurance reports from Service User Safety Group to QAC. Learning from incidents reported to QAC on a quarterly basis. Quarterly mortality reports to QAC.	National Reporting Learning System report (bi-annual).		Significant

Action No: 1	Responsible Person: Mike Hunter	Target Date: 30/03/2018

Action Details	Action Progress
Implementation plan in place and being monitored.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY. Strategic 1.3 Provide Positive Experiences And Outcomes For Service Users

Risk Ref: A103 v.1 Executive Lead: Medical Director	Risk Rating:	Impact	Likelihood	Score	Reviews	
Failure to comprehensively capture the experience of our service users and take appropriate action.	Residual Risk (with current controls):	3	2	6	Last Review:	30/10/2017
	Target Risk (after improved controls):	2	1	2	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Implementation of the 5-Year Service User Engagement Strategy.	Service User Engagement Strategy Implementation Plan not fully embedded.	Quarterly Service User Engagement Group assurance reports (including Friends and Family data) to QAC. Quarterly Complaints & Compliments report to QAC. Innovation & Inclusion Manager appointed to drive service user engagement implementation strategy. Paper presented to QAC in Oct 17 detailing next stage of strategy implementation.	Care Quality Commission inspection reports - March 17. Monthly national benchmarking data from FFT. Continuous Care Opinion Feedback.	Improvements required in FFT and Care Opinion systems in order to adequately manage and learn from feedback.	Moderate
Service Users involved in Microsystem projects within teams.		Quarterly reports to QAC.			Significant
Service User recruited within QI Team to strengthen engagement across the Trust.					Significant
Friends and Family Test in place.		Data reported to QAC.	Monthly national benchmarking data from FFT.		Significant

Action No: 2 Responsible Person: Tania Baxter Target Date: 30/03/2018

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.3 Provide Positive Experiences And Outcomes For Service Users

Action Details	Action Progress
Work with directorates to improve the utilisation of Care Opinion to capture feedback and learn from it.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.4 Timely Access To Effective Care

Risk Ref: A104I v.1 Executive Lead: Deputy Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
Failure to achieve national performance targets for Improving Access to Psychological Therapies (IAPT) and Earling Intervention in Psychosis (EIP) services.	Residual Risk (with current controls):	4	4	16	Last Review:	30/10/2017
	Target Risk (after improved controls):	1	3	3	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Monthly monitoring of national waiting times. Contract in place with Commissioners.		Clinical and corporate monthly performance report to FIC, QAC, EDG and BoD. Quarterly service reviews. Year end negotiation with Commissioners.	Reporting via Unify for EIP and IAPT. Monthly report to NHS England. Contract Management Group meets monthly and Board bi-monthly to review investment and performance.		Significant
Quality Standards within CCG contract.		Monthly performance reports to EDG/QAC/Board.	Monthly Quality Performance Review Group (CCG).		Significant
New EIP clinical structure agreed. As part of the CMHT reconfiguration additional posts have been identified and appointed to through the preferencing process.		CMHT reconfiguration updates to TOG.			Moderate
Negotiations with CCG resulted in successfully securing additional funds to address increased demand. £650k p/a recurrent.					Significant
Review of Trust's interpretation of EIP standards against a regional benchmark complete. Reports are now in line with other regional providers providing the Trust with	Understand how benchmarking data influences planning in the organisation.	Benchmarking data reported to QAC.			Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY. | Strategic | 1.4 Timely Access To Effective Care

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
effective and reliable benchmarking statistics.					

Action No: 2	Responsible Person: Clive Clarke	Target Date: 31/10/2017

Action Details	Action Progress
CliKView system to become operational.	ClikView going live w/c 30/10/17 for EIP. No current plans for ClikView for IAPT.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY.	Strategic	1.4 Timely Access To Effective Care

Risk Ref: A104II v.1 Executive Lead: Deputy Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
A lack of ability to influence our Commissioner's intentions.	Residual Risk (with current controls):	4	2	8	Last Review:	30/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Trust working with Commissioners on Transformation Agenda (led by LDS and MH Delivery Boards with key clinical individuals working into projects). Commissioning intentions agreed with CCG. Escalation procedures in place.		Fortnightly contract update report provided to Business Planning Group (as subgroup of EDG). Two-monthly reports to FIC on contract performance.	Contract Management Group (NHS SCCG & SCC) meet monthly and Board bi-monthly. Board to Board meetings with NHS SCCG and SYHA 13/9/17 to be followed up in six months. Quarterly review with NHS Improvement on contract performance. Contract monitoring with NHS England. Contract monitoring with SCC.	No underpinning contract in place with SCC.	Moderate
Joint Director of Strategic Commissioning post in place.					Significant
Governance arrangements for Transformation Agenda agreed. Development Board chaired by Kevan Taylor who also sits on the Executive.					Significant
Identified CCG individual to lead on developing a city-wide dementia strategy.	City-wide dementia strategy to support the future of Trust services not yet in place.				Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY. | Strategic | 1.4 Timely Access To Effective Care

Action No: 2	Responsible Person: Clive Clarke	Target Date: 23/03/2018

Action Details	Action Progress
Transformation project addressing the lack of a city-wide dementia strategy.	New CCG lead identified to take forward city-wide dementia strategy. This will feed into the mental health and learning disability delivery boards.

Action No: 3	Responsible Person: Clive Clarke	Target Date: 30/03/2018

Action Details	Action Progress
Contract Management Group meet with SCC and SCCG to develop and agree a new contract.	Currently working out details for 18/19 contract. Supply agreement ready to be signed subject to further negotiations on pension risk.

Action No: 4	Responsible Person: Clive Clarke	Target Date: 29/12/2017

Action Details	Action Progress
3 organisations including SHSC working together to identify a single efficiency total. The process is managed by SHSC across the whole of mental health, learning disability and continued health care (dementia) spend.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.1 We Will Manage Change Positively And Effectively Ensuring Support For Staff.

Risk Ref: A201 v.1 Executive Lead: Director - Human Resources	Risk Rating:	Impact	Likelihood	Score	Reviews	
An inability to re-deploy staff as a result of organisational change.	Residual Risk (with current controls):	3	2	6	Last Review:	23/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Redeployment Co-ordination Group established and redeployment process in place.		Redeployment Co-ordination Group reports to Vacancy Control Panel (VCP) - Monthly. VCP exception report contained within Workforce Report to WODC - Quarterly. Redeployment policy in place.			Significant

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.2 We Will Develop A Strategic Approach To Enable Workforce Transformation

Risk Ref: A202 v.1 Executive Lead: Director - Human Resources

Failure to develop a sustainable and integrated workforce strategy including a clear understanding of our current and future workforce requirements and how we work effectively with partners to delivery the strategy.

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	2	8
Target Risk (after improved controls):	2	2	4

Reviews

Last Review: 23/10/2017

Next Review: 22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Bank Staffing Group, Agency and Off Payroll Group, Safer Staffing Group, Rostering to be overseen by the Effective Staffing Group.		Quarterly Effective Staffing Group reports to WODC. Workforce In-Year monitoring return to NHS Improvement. Monthly report to NHS I on nursing agency/bank usage.	Contract monitoring report to NHS SCCG. Internal Audit Report on Safe Staffing gave 'significant assurance' (May 17).		Significant
Joint group with nursing to review specific challenges e.g. qualified nursing.					Significant
Effective Staffing Group (ESG) operational from August 2017.		Quarterly ESG reports to WODC.			Significant
Health Education England annual workforce planning return.			Follow up meeting with all returning officers for moderation by Health Education England (annual).		Significant
Workforce Strategy approved by Board Sept 17.	Action plan being developed.	Quarterly action plan progress reports to WODC from Oct 17.			Significant
Separate KPI appendix to the delivery plan agreed at WODC on 25/10/17.					Significant

Action No: 1 Responsible Person: Dean Wilson Target Date: 08/11/2017

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.2 We Will Develop A Strategic Approach To Enable Workforce Transformation

Action Details	Action Progress
Workforce Strategy action plan to be approved by BoD. Taken to October Board for Executive and Non-Executive comments. Following this, the action plan will be taken to November 2017 Board for sign off.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.3 We Will Promote An Effective Culture Of Leadership And Amangement Based On Trust Values.

Risk Ref: A203 v.1 Executive Lead: Director - Human Resources	Risk Rating:	Impact	Likelihood	Score	Reviews	
Risk of disconnect between Trust values and operational delivery, plus reputational risk from poor management practice.	Residual Risk (with current controls):	3	2	6	Last Review:	23/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Review of and learning from employment tribunals.	Lack of systematic review and follow up following Employment Tribunals.	Disciplinary policy in place. Capability policy in place.			Moderate
Leadership programme agreed via EDG.	Progress made, but implementation required for a number of modules for the Leadership programme.	Progress of Leadership Programme included in workforce report to WODC and where appropriate to the Board.			Moderate
Good engagement with Schwarz Rounds.					Significant
PDR compliance.					Significant
Coaching Service established and operational.	No current reporting mechanisms to show effectiveness of service.				Moderate
Microsystems developed and involved in projects.		Quarterly reports to QAC.			Significant
Values-based recruitment operational.		Recruitment policy.			Significant
Annual Staff Survey, Friends and Family Test operational.		Progress reports on Staff Survey Action Plan to WODC (quarterly).	Friends and Family Test (FFT) Monthly contract management meeting with CCG (CQUiN).		Significant
Workplace Wellbeing Service.		Exception reports to HR SMT and WODC bi-annually. Associated CQUIN for Workplace Wellbeing.	Monthly contract management meeting with CCG		Significant

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.3 We Will Promote An Effective Culture Of Leadership And Amangement Based On Trust Values.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
		Progress against CQUiN reported to WODC quarterly.			

Action No: 1	Responsible Person: Dean Wilson	Target Date: 13/12/2017
Action Details	**Action Progress**	
Roll out of leadership programme under development.		

Action No: 2	Responsible Person: Dean Wilson	Target Date: 29/12/2017
Action Details	**Action Progress**	
Introduce systematic process for learning from Employment Tribunals.		

Action No: 3	Responsible Person: Dean Wilson	Target Date: 31/01/2018
Action Details	**Action Progress**	
Introduce coaching service report to WODC.		

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.4 We Will Prioritise The Health And Wellbeing Of Our Employees

Risk Ref: A204 v.1 Executive Lead: Director - Human Resources	Risk Rating:	Impact	Likelihood	Score	Reviews	
Risk of low motivation and morale compromises staff motivation.	Residual Risk (with current controls):	3	3	9	Last Review:	23/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	22/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Underpinning governance providing support for staff.		Numerous support and engagement groups in place including Health & Wellbeing Group, Workplace Wellbeing, IAPT. Progress against Staff Survey action plan reported to WODC. Psychological Service advertised to staff and become operational from 25/10/17.			Significant
A CQUIN for health and wellbeing in place.		Progress against CQUiN reported to WODC quarterly.	Monthly contract management meeting with CCG.		Significant
Physio Med service in place for Muscular Skeletal issues.					Significant
Communications Strategy developed.	Communications strategy awaiting final approval.	Clarity of communication and consistency of Trust messages via a number of mechanisms including Chief Executive letter, directorate communication structure, communication digest etc.			Moderate
Proactive sessions provided by Workplace Wellbeing for		WWB report to WODC identifying issues so that			Significant

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic	2.4 We Will Prioritise The Health And Wellbeing Of Our Employees

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
staff/teams undergoing organisational change.		support can be provided where needed.			

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic	3.1 Deliver Interventions And Support Closer To General Practice, Neighbourhoods And Embedded Within Our Services

Risk Ref: A301 v.1 Executive Lead: Deputy Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
Lack of Primary Care Strategy.	Residual Risk (with current controls):	3	3	9	Last Review:	26/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	25/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
EDG met (June 17) to begin the process of developing a primary care strategy. Strategy developed through EDG and BoD Development sessions in July and August 2017.	SHSC Primary Care strategy not yet in place which will encompass both our future intentions and how current services provided by SHSC can be more primary care facing.	Alignment to CCG & PCS Primary Care Strategy (Board Development Session Aug 2017).			Moderate

Action No: 4	Responsible Person: Phillip Easthope	Target Date: 31/01/2018

Action Details	Action Progress
Draft strategy to Board.	Was not submitted to the October 2017 Board. Now rescheduled for January 2017.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic	3.2 Collaborate And Work With Partners To Support Shared Aims Of Delivery Quality Care And Support

Risk Ref: A302 v.1 Executive Lead: Deputy Chief Executive

Lack of a Trust framework and a lack of understanding of the Trust's model for collaborative working.

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	2	3	6
Target Risk (after improved controls):	2	2	4

Reviews	
Last Review:	30/10/2017
Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
	No partnership engagement framework in place.	Individual reports to EDG Strategy sessions and TMG regarding service development opportunities (as and when).			Limited

Action No: 1	Responsible Person: Fiona Goudie	Target Date: 29/12/2017

Action Details	Action Progress
Production of Partnership Engagement Framework.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic	3.3 Provide Effective Community Care And Treatment

Risk Ref: A303 v.1 Executive Lead: Deputy Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration.	Residual Risk (with current controls):	3	4	12	Last Review:	30/10/2017
	Target Risk (after improved controls):	2	2	4	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Clear Community Mental Health Team reconfiguration implementation plan in place with agreed timescales.	Staffing issues i.e. temporary posts/sickness/vacancies which can undermine quality during the transitional period.	Monthly reconfiguration update to EDG. Mobilisation updates to EDG. Safety dashboard to QAC/BoD and full performance report to EDG (monthly). Quality Impact Assessments being undertaken to monitor change. Regular meetings with staff. Co-creation of care pathways be staff and service users. Transition plan in place.	Monthly contract meeting with NHS SCCG.		Significant

Action No: 1 Responsible Person: Michelle Fearon	Target Date: 31/01/2018
Action Details	Action Progress
Agreed action plan in place and being implemented.	Mobilisation plan in place. Preferencing taken place with 86% of staff securing 1st choice, 10% securing their second and 4% their 3rd choice. Anticipated all will bein post by end January 2018.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic	3.4 Provision Of High Quality Inpatient Services Supported By Effective Alternatives

Risk Ref: A304 v.1 Executive Lead: Deputy Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
There is a lack of community provision in place as an alternative to inpatient care.	Residual Risk (with current controls):	3	3	9	Last Review:	30/10/2017
	Target Risk (after improved controls):	2	3	6	Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Gaps in Assurance**	**Rating**
A review of step-up beds has been completed and has informed a new specification.		Report on Crisis House to FIC, BPG and EDG October 2017.	Monthly contracting meeting NHS SCCG.		Significant
Tender specification for the Crisis House completed and tender process began October 2017.					Significant

Action No: 1	Responsible Person: Michelle Fearon	Target Date: 01/04/2018

Action Details	Action Progress
Developing a tender specification for the crisis house. Tender process to begin in October 2017 with service commencing April 2018.	Tender specification completed and notice of interest published. On target for new service to commence 1/4/18.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.1 We Will Improve The Productivity And Efficiency Of Our Services

Risk Ref: A401I v.1 Executive Lead: Executive Director - Finance	Risk Rating:	Impact	Likelihood	Score	Reviews	
Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes.	Residual Risk (with current controls):	4	2	8	Last Review:	26/10/2017
	Target Risk (after improved controls):	3	2	6	Next Review:	25/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Strong financial management.		Monthly finance report to Board.	Internal Audit report providing significant assurance on financial management (June 17). NHS I quarterly monitoring review letter. Head of Internal Audit Opinion. Year End Report to those responsible for governance. Annual Governance Statement. Corporate Governance Statement.		Significant
Financial Plan including CIP	Lack of understanding of productivity across all services.	CIP and Disinvestment reporting (TOG, FIC & EDG).			Significant
Governance and reporting arrangements in place.	Weaknesses in financial governance at directorate level. Lack of consistency of directorate financial management.	Monthly finance report to Board, EDG, FIC, TOG & BPG.			Moderate

Action No:	2	Responsible Person:	Phillip Easthope	Target Date:	30/03/2018

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.1 We Will Improve The Productivity And Efficiency Of Our Services

Action Details	Action Progress
Productivity KPI and/or benchmark on cost for all clinical and corporate services.	NHS benchmarking data club data on clinical services received. Corporate data outstanding. NHS Improvement has requested data for corporate services which is due to be submitted November 2017. Anticipate having reliable data to inform 18/19 planning round.

Action No: 3 Responsible Person: Phillip Easthope Target Date: 29/12/2017

Action Details	Action Progress
Standardisation of financial governance through clinical directorate restructure.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.1 We Will Improve The Productivity And Efficiency Of Our Services

Risk Ref: A401II v.1 Executive Lead: Chief Executive	Risk Rating:	Impact	Likelihood	Score	Reviews	
Trust governance systems are not sufficiently embedded.	Residual Risk (with current controls):	3	4	12	Last Review:	26/10/2017
	Target Risk (after improved controls):	3	2	6	Next Review:	25/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Established board committees providing assurance to the Board.	Lack of clarity of assurance responsibilities within terms of reference for each board committee. Appropriate challenge and performance management of information at operational group level prior to presentation to Board Committees.	Minutes of committees. Annual Report. Existing terms of reference and work programmes currently in place. Significant issues report to board from each committee.	Annual Head of Audit Opinion. CQC Well-Led and comprehensive review (2-yearly). Internal audit reports. Quarterly NHS Improvement Review Meetings.	Head of Audit Opinion for 16/17 - limited. Embedding of assurance systems and processes.	Limited
Risk Management Strategy 2016 in place.	2017 strategy not yet approved and in place	Approval by Audit Committee and Board 2016. Annual Governance Statement. Corporate Governance Statement.		Audit of team and directorate risk registers.	Moderate
Policy system management in place.	Policy System Management process insufficiently embedded in the organisation.	Policy Governance Group reports to EDG and CQC Task and Finish Group.	IA 360 Assure report Sept 17		Limited
Meeting statutory requirements of commissioners and regulators.		Provider licence self-certification. Annual governance statement. Corporate governance	Quarterly meetings with NHS Improvement.		Significant

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.1 We Will Improve The Productivity And Efficiency Of Our Services

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
		statement. Quarterly returns to NHS Improvement. Contract Management Board. Board to Board meetings with commissioners.			

Action No: 1	Responsible Person: Margaret Saunders	Target Date: 30/03/2018
Action Details	**Action Progress**	
Action plan prepared with recommendations from 360 Assurance Trust Committee Governance Audit follow up.		

Action No: 2	Responsible Person: Margaret Saunders	Target Date: 30/11/2017
Action Details	**Action Progress**	
Risk Management Strategy to be taken to Audit Committee (Oct 17) for comments, EDG (Oct 17) and for Board approval (Nov 17).		

Action No: 3	Responsible Person: Margaret Saunders	Target Date: 31/01/2018
Action Details	**Action Progress**	
Committee Terms of Reference are being reviewed for consistency and clarity.		

Action No: 4	Responsible Person: Samantha Stoddart	Target Date: 31/01/2018
Action Details	**Action Progress**	
Internal Audit of Trust's team, directorate and corporate risk registers. Due for completed end 2017, to be presented to Audit Committee January 2018.		

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY | Strategic 4.2 We Will Adapt Some Of The Services We Provide In Response To Demand And Market Conditions

Risk Ref: A402 v.1 Executive Lead: Deputy Chief Executive

There is a lack of a public health-driven commissioning strategy.

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	3	9
Target Risk (after improved controls):	2	3	6

Reviews	
Last Review:	30/10/2017
Next Review:	29/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Performance data provides clear indications of needs/trends/gaps that enable forward thinking and influencing of partners.	No systems currently in place to ensure that performance data/intelligence is fed into relevant delivery boards.				Moderate
Implementation of 5 Year Forward View. Additional recurrent funding secured for EIP and Liaison Psychiatry.		Report of implementation of 5 Year Forward View to EDG and Board (Jun 17). Transformational Operational Group (TOG) reports on service development plans based on 5 Year Forward View.			Moderate
New governance structure agreed for Delivery Board which facilitates Trust's ability to influence the transformation agenda. Chaired by Kevan Taylor.					Moderate

Action No: 2 Responsible Person: Phillip Easthope Target Date: 30/03/2018

Action Details	Action Progress
Development of ClikView to capture realtime data. This is a presentational tool showing data which can be analysed.	Seven dashboards now operational (incidents, acute inpatients, specialist, HR, Clustering, EIP, user's audit) Executive dashboard requires completion. Additional dashboards can be developed subject to the engagement of services. Effectiveness of ClikView tested through the user's audit which will show how dashboards are being used.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.3 An Estate Plan That Meets Our Needs

Risk Ref: A403 v.1 Executive Lead: Executive Director - Finance	Risk Rating:	Impact	Likelihood	Score	Reviews	
Interdependencies of reconfiguration of community and inpatient service restructure are not aligned with the Estate Plan and associated funding.	Residual Risk (with current controls):	4	3	12	Last Review:	26/10/2017
	Target Risk (after improved controls):	3	2	6	Next Review:	25/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Approved Estates Strategy	Strategy Implementation Plans not fully developed - gaps around estate utilisation and maximisation. Estates related funding requirements for community restructure not yet clear and will link to disposal and acquisition of properties.	Estates Strategy update to BPG.	External monthly project management (Arcadis) reports to Capital Board re ACR Phase 2.	Full development of implementation plans. Capacity and capability to deliver estate strategy. Estimated and tendered costs for estates solutions for community reconfiguration. Overall financial appraisal (capital and revenue).	Moderate
Governance and reporting arrangements in place through EDG via TOG/BPG.	TOG reporting/governance processes.	TOG minutes and Checkpoint Reports and Status Reports.			Moderate
Capital Board oversight.	Capital funding requirements for ACR Phase 2 best estimates only. Overall potential impact on capital and revenue not yet clear.	Capital Board minutes (monthly).		Tendered capital costs for ACR Phase 2	Moderate
Only Board can approve sale of assets.					Moderate
Stakeholder meetings held with all relevant community and inpatient service managers. Outcomes have informed the development of the plan to deliver the estates strategy.					Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY | Strategic | 4.3 An Estate Plan That Meets Our Needs

Action No: 1	Responsible Person: Phillip Easthope	Target Date: 29/12/2017
Action Details	**Action Progress**	
Implementation plan updates.	Estates Strategy Implementation update going to TOG Nov 17 meeting, BPG Dec 17 meeting.	

Action No: 2	Responsible Person: Phillip Easthope	Target Date: 30/11/2017
Action Details	**Action Progress**	
Ensure TOG governance processes are embedded.		

Action No: 4	Responsible Person: Helen Payne	Target Date: 28/02/2018
Action Details	**Action Progress**	
Construction tendering informs actual capital funding requirement for ACR Phase 2. This will inform overall capital and revenue impacts.		

Action No: 5	Responsible Person: Helen Payne	Target Date: 29/12/2017
Action Details	**Action Progress**	
Plan for community restructure estates solutions with inform funding requirements (and disposals/acquisitions) via a business case. This will inform overall capital and revenue impacts.		

Action No: 7	Responsible Person: Helen Payne	Target Date: 31/01/2018
Action Details	**Action Progress**	
To clarify estates-related funding requirements work has taken place to support adult cmht and IAPT service to establish interim estates solution.	Initial stakeholder meeting taking place in order to develop specification for Health & Wellbeing Hubs which are intended to be final solution for CMHT reconfiguration.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic	4.4 Use Technology To Deliver New Ways Of Working And New Care Models

Risk Ref: A404 v.1 Executive Lead: Executive Director - Finance

There is a lack of embeddedness of digital strategy and interdependencies with associated strategies.

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	4	12
Target Risk (after improved controls):	2	4	8

Reviews	
Last Review:	26/10/2017
Next Review:	25/11/2017

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	Rating
Compliance with IT Strategy (dynamic).		Data and Information Governance Board (DIGB) Business Planning Group (BPG).	Auditors (specific audits) and NHS England Digital Maturity Toolkit.	External assurance on IT Strategy.	Significant
Digital Transformation and Business Planning governance frameworks and mechanisms.	Embedding new mechanisms and develop implementation plans when required.				Significant

Action No: 1	Responsible Person:	Target Date: 29/12/2017

Action Details	Action Progress
Improve engagement with Digital Transformation Strategy.	