BOARD OF DIRECTORS MEETING (Open)

Date: 13 March 2019 **Item Ref:** 7

TITLE OF PAPER	**Board Assurance Framework (BAF) 2018/19**
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	For discussion

OUTCOME	To provide assurance to the Board that utilising the Board Assurance Framework (BAF), complemented by the risk management Strategy, the Trust has systematically managed the principal risks identified in achieving its objectives.
TIMETABLE FOR DECISION	13 March 2019
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management Directorate Risk Registers Risk Management Strategy Shaping the Future, the Trust Strategy & Strategic Planning Framework 2017-2020 Corporate (organisational) Risk Register Care Network and Directorate Risk Registers
STRATEGIC AIM: **STRATEGIC OBJECTIVE:** **BAF RISK NUMBER:** **BAF RISK DESCRIPTION:**	Value for Money We will improve the productivity and efficiency of our services A401ii Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective risk management of risk and service quality.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND 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	February 2019

SUMMARY REPORT

Report to: Board of Directors
Date: 13 March 2019
Subject: Board Assurance Framework (BAF) 2018/19
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)*
		x			

2. Summary

The Trust aspires to be outstanding in relation to its corporate governance. Evidence that would support achievement of this would be:

a) Meeting 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

b) Having a board assurance framework (BAF) and risk registers in place which are assessed by the board on a quarterly basis as a minimum as set down in the development reviews of leadership and governance using the well-led framework, https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

c) Securing an significant Head of Internal Audit Opinion (HIAO)

The Trust currently has a) and b) in place and a moderate HIAO for 2017/18. Work will continue during 2018/19 to improve the latter.

2.1 Board Assurance Framework Purpose

The BAF is a key aspect of good governance in all organisations and a properly functioning BAF provides Board members with an understanding of the principal risks to achieving its strategic objectives. It also provides assurance regarding controls in place or actions being taken to mitigate risks to an acceptable level within the Board's risk appetite.

The BAF is dynamic document and enables risks to evolve to reflect changing external and internal environments. As such, it is expected that some risks will close over the course of a year once controlled to an acceptable level, or risks may change to reflect emerging issues and priorities.

Within Shaping the Future, the Trust Strategy & Strategic Planning Framework 2017-2020 operational priorities are identified and reviewed annually. Nine priorities were agreed for 2018/19 and any risks to achieving these have been incorporated into the current BAF.

2.2 BAF Operation

The BAF is fully automated via the Ulysses Risk Management System (URMS) and risks are updated by risk owners and are quality assured by Executive Directors. Each BAF risk is assigned and presented to the appropriate Board Committee for consideration and review on a quarterly basis. In order to help Committees determine the level of management and assurance received from the BAF risks, report front sheets require the author to identify the relevant BAF risk. Any concerns Board Committees have in relation to the BAF are recorded in the 'significant issues' report they present to the Board.

In order to ensure that the most current version of the BAF is presented to the Board, it was agreed with the Audit Committee Chair that, going forward, the month after the BAF is presented to Board committees will be used to make changes and updates prior to presentation of a completely revised BAF to Board the following month. The reporting intervals will not change and remain quarterly.

2.3 2018/19 BAF

The last iteration of the 2018/19 BAF was presented to the following committees for review and comment:

- Audit Committee on 22 January 2019
- Finance, Information and Performance Committee on 28 January 2019
- Quality Assurance Committee on 28 January 2019
- Workforce and OD Committee on 31 January 2019

Comments from Board committees have been incorporated into this iteration of the BAF presented today.

The Board is asked to pay particular attention to Risks A104ii and A302ii for which it is directly responsible. However, it was agreed in the development session on 27 February that risk A104ii would be closed so this will be its final presentation to Board.

2.4 Changes to BAF since last presentation to Board in November 2018

At the November 2018 Board meeting it was agreed that the number of controls should with reviewed and rationalised with a view to reducing the overall size of the BAF. A meeting took place with the Audit Chair to review the content of this report and suggested improvements to the BAF.

As a result a comprehensive review of the BAF has taken place resulting in the rationalisation of a significant number of controls on a number of risks, review of risk descriptions and review of assurance ratings. These changes also reflect the outcome of the CQC Well-led inspection and the Trust's responding action plan. The Board can review all changes since November 2018 in Appendix 1. Appendix 2 details those Committees to which BAF risks are linked and links with risks on the Corporate Risk Register (CRR).

It should be noted that the final iteration of the 2018/19 BAF which will be presented to the Board in June 2019 will reflect discussions at the Board Development session on 27 February 2019.

Risk A104i has been closed **'**failure to consistently achieve national performance targets for IAPT'. Targets have been consistently met in 2018/19 with one deviation only in May 2018. The matter no longer poses a risk to meeting strategic objectives and therefore no longer needs to be included on the BAF. Assurance on continued performance will be provided to Board through the Performance Report and Significant Issues Report from FIPC.

2.5 Assurances

The Board is asked to note that the BAF report does not provide an overall assurance rating for each risk. Assurance ratings are assigned to each control within a risk.

In order to provide the Board with some indication of assurance, the table below shows the assurance ratings for each control within a risk. New to this summary report is an indication of the change in assurance ratings which is based on a like-for-like comparison of control assurances where this has been available, but where it has not because of significant changes in controls, an overall view has been taken. The Board is asked to note that the 'gaps in assurance' column on the report now also refers to negative assurance.

Reductions in assurances can primarily be attributed to the outcome of the CQC Well-led inspection which was received and responded to after the last Audit Committee.

Risk N^{o}	Assurance Level for controls	Change in Assurance Ratings	Risk N^{o}	Assurance Level for controls	Change in Assurance Ratings
A101i	Control 1: limited		**A101ii**	Control 1: limited Control 2: moderate Control 3: limited Control 4: moderate Control 5: significant Control 6: moderate	
A102i	Control 1: limited Control 2: moderate		**A102ii**	Control 1: limited Control 2: significant Control 3: moderate Control 4: significant	
A104i	Risk Closed		**A104ii**	Control 1: moderate	
A202	Control 1: limited Control 2: moderate		**A203**	Control 1: moderate Control 2: moderate Control 3: limited Control 4: moderate	
A204	Control 1: limited Control 2: significant Control 3: full Control 4: moderate		**A302ii**	Control 1: moderate Control 2: moderate Control 3: moderate	

Risk N^{o}	Assurance Level for controls	Change in Assurance Ratings	Risk N^{o}	Assurance Level for controls	Change in Assurance Ratings
A303	Control 1: moderate Control 2: moderate Control 3: significant		**A303ii**	Control 1: significant Control 2: significant Control 3: significant Control 4: moderate	
A401i	Control 1: moderate		**A401ii**	Control 1: moderate Control 2: limited Control 3: limited	
A403	Control 1: significant Control 2: moderate Control 3: moderate		**A404**	Control 1: significant Control 2: moderate	

3. Next Steps

The Board Committees support the internal assurance mechanisms employed in the Trust. In line with reporting requirements set out in the Trust's Risk Management Strategy for quarterly presentation, the final 2018/19 BAF will be presented to all Board committees during April 2019, updated in May and presented to the Board in June 2019 along with a draft of the 2019/20 BAF.

4. Required Actions

The Board is asked to:

a) Receive and approve the BAF.

b) The Board is asked to consider papers presented at today's meeting with a view to identifying how assurance can be gained from them that actions on the BAF are being sufficiently mitigated and:

- record and minute any assurance that has been provided (or not) during the meeting regarding the relevant risks;
- provide the Director of Corporate Governance (Board Secretary) with any updates that are required to the BAF following the Board.

5. Monitoring Arrangements

The BAF and Corporate Risk Register are 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

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Risk Number	Changes and Assurance Provided
A101i	**Executive Lead: Executive Director of Nursing, Professions & Care Standards**
	"Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance)"
	The control relating to the Mental Health Act and Mental Capacity Act has been closed because this is no longer a significant risk that requires oversight on the BAF as governance structures have been successfully implemented which now provides assurance of the Trust's adherence to the regulations. Reporting arrangements are in place via QAC. A new single control has replaced the remaining two controls to reflect the outcome of the latest CQC Well-Led Inspection and the governance structures which have been put in place to address necessary actions and provide assurance to Board and its committees. Both actions closed as complete. No current actions as the governance arrangements for the oversight and implementation of the CQC action plan is identified as a control.
A101ii	**Executive Lead: Executive Medical Director**
	"Inability to provide assurance regarding improvement in the quality of patient care"
	3 controls closed – no longer applicable or merged into new control Control 1: new external assurance and gap in assurance added. Assurance rating reduced from moderate to limited Control 2: no change Control 3: control amended (monitoring through SUEG not QAC), new internal assurance added, gap in assurance expanded. Control 4: updated, external assurance date change Control 5: internal assurance expended Control 6: new control Action 1: progress added, responsible person amended and timescale extended by 3 months Action 2: new action 3 actions closed and covered by new action.
A102i	**Executive Lead: Executive Director of Nursing, Professions & Care Standards**
	"Failure to deliver safe care due to insufficient numbers of appropriately trained *registered professionals*" (*updated risk description*)
	Control 1: There were previously 8 separate controls within this one control. This has been reduced to 3. All gaps in assurance have been amended. Four previous external assurances have been reduced to one and new gap in assurance added. Assurance rating reduced from moderate to limited. Control 2: No change All 3 previous actions closed and replaced with 3 new actions to address

Risk Number	Changes and Assurance Provided
	updated gaps in control.
A102ii	**Executive Lead: Executive Medical Director**
	"Inability to provide assurance regarding improvement in the safety of patient care"
	Previously 10 controls. These have been consolidated and reduced to four. Control 1: description updated, gap in control removed, internal assurances updated and one new one added, external assurance updated Control 2: no change to description, new internal assurance added Control 3: no change to description, new internal, external and gap in assurances added and assurance rating reduced from significant to moderate Control 4: new control All four previous actions have been closed and replaced by 1 new overarching action.
A104i	**Executive Lead: Executive Director of Operations**
	"Failure to consistently achieve national performance targets for IAPT" Risk description has been amended. Reference to EIP has been removed as targets are now consistently being met.
	RISK CLOSED – SEE PAGE 4 FOR RATIONALE
A104ii	**Executive Lead: Executive Director of Operations**
	"Failure to produce a citywide dementia strategy could impact on the co-ordination of citywide commissioning for dementia services"
	Control 1: no change Action 1: progress added Following the completion of the consultation and approval of a citywide dementia strategy and the impact this will have on commissioning of the Trust's dementia services, this risk is likely to close.
A202	**Executive Lead: Director of Human Resources**
	"There is a risk that the Trust does not identify and develop new roles to meet current and future workforce needs" Whole risk description changed
	Previously 8 controls. These have been consolidated and reduced to two. Control 1: no change to description, gap in control added, one internal assurance removed, external assurances updated and assurance rating reduced from significant to limited. Gap in assurance added Control 2: slight change to description, assurance rating reduced from significant to moderate Action 1: progress update added Action 2: progress update added Action 3: new

Risk Number	Changes and Assurance Provided
A203	**Executive Lead: Director of Human Resources**
	"Values not embedded consistently across the Trust which may impact on employee relations" Whole risk description changed
	Previously 13 controls – reduced and amalgamated into 4 better defined controls Control 1: new Control 2: new Control 3: new Control 4: new Two previous actions closed as no longer relevant. New action created which once in place will drive all actions and changes.
A204	**Executive Lead: Director of Human Resources**
	"Risk of reduced productivity and service quality as a result of low morale and motivation" Whole risk description change
	Previously 9 controls – reduced and amalgamated into 4 better defined controls Control 1: reworded, internal assurances removed as now part of control, external assurances updated, gap in assurance added and assurance rating reduced from moderate to limited. Control 2: no change Control 3: new Control 4: new Action 1: description amended and progress added. Timescale extended by 1 month. Action 2: new Action 3: new
A302ii	**Executive Lead: Executive Director of Operations**
	"There is a risk to implementation of the Community Wellbeing Strategy due to capacity issues within the Trust and from competing Trust priorities"
	2 controls closed as not relating to capacity issues Control 1: no change Control 2: PCS changed to primary care as working with whole of primary care Control 3: no change Action 1: updated and timescale extended by 2 months 2 actions closed as related to closed controls
A303	**Executive Lead: Executive Director of Operations**
	"Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration"
	Previously 8 controls – reduced and amalgamated into 3 Control 1: updated and gap in control removed Control 2: updated Control 3: new (amalgamation of previous controls) Action 1: progress updated provided and timescale extended by 3 months

Risk Number	Changes and Assurance Provided
A303ii	**Executive Lead: Executive Director of Operations**
	"Risk to the timely completion of the *Decisions Unit (formerly known as PDU)* due to lack of clinical and project capacity" Risk description amended (in italics)
	1 control closed as not relevant. Control 1: updated, gap in control removed and assurance rating increased to significant from moderate Control 2: no change Control 3: gap in control removed and assurance rating increased to significant from moderate Control 4: new control Both actions completed and closed. No current actions. Risk will be closed at next iteration.
A401i	**Executive Lead: Executive Director of Finance**
	"The Trust will not continue to be financially sustainable and that plans will not deliver the required financial savings"
	3 controls reduced to one Control 1: control updated, revised gap in control, external assurance and gaps in assurance rationalised Action 1: progress added and timescale extended by 3 months Action 2: progress added and timescale extended by 3 months 2 actions closed
A401ii	**Executive Lead: Chief Executive (Director of Corporate Governance)**
	"Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation."
	Six controls revised and reduced to 3 Control 1: revised description, new gap in control, internal assurances amended/updated, one external assurance removed and gap in assurance revised Control 2: 1 internal assurance removed as not relevant, external assurance updated Control 3: external assurance updated and one added, 2 new gaps in assurance Action 1: progress added and timescale extended by 3 months Action 2: progress added and timescale extended by 6 months Action 3: progress added and timescale extended by 2 months Action 4: progress added and timescale extended by 1 month 1 action closed as now included in 360 Assurance review of operational risk management
A403	**Executive Lead: Executive Director of Finance**
	"Final business cases in relation to the Acute Care Reconfiguration Phase II at Longley Centre are not approved"
	Control 1: no change Control 2: no change Control 3: no change

Risk Number	Changes and Assurance Provided
	Action 1: progress added and timescale extended by 5 months Action 2: progress added and timescale extended by 3 months 3 new actions
A404	**Executive Lead: Executive Director of Finance**
	"The programmes for delivery are not developed or require additional resources not within plan and/or require significant re-prioritisation once developed"
	1 control closed as not relevant Control 1: no change Control 2: description updated, new gap in control added, internal assurance removed, gap in assurance changed Action 1: progress added and timescale extended by 2 months Action 2: progress added and timescale extended by 2 months Action 3: no change – on target Action 4: new action Action closed as now developed in to action 4 above.

Appendix 2

Links between Board Assurance Framework, Corporate Risk Register and Board Committees 2018/19

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).	3679	QAC
A101ii	Inability to provide assurance regarding improvements in the quality of patient care.	3916 4012 4140	QAC QAC QAC
A102i	Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.	3831	WODC
A102ii	Inability to provide assurance regarding improvement in the safety of patient care.	3917 4021 4079	QAC WODC QAC
A104ii	Failure to produce a citywide dementia strategy could impact on the coordination of citywide commissioning for dementia services.		Trust Board
A202	There is a risk that the Trust does not identify and develop new roles to meet current and future workforce needs.		WODC
A203	Values not embedded consistently across the Trust which may impact on employee relations		WODC
A204	Risk of reduced productivity and service quality as a result of low morale and motivation.	4078 4124	WODC WODC
A302ii	There is a risk to implementation of the Community Wellbeing Strategy due to capacity issues within the Trust and from competing Trust priorities.		Trust Board
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration		QAC
A303ii	Risk to the timely completion of the Decisions Unit due to lack of clinical and project capacity		FIPC
A401i	The Trust will not continue to be financially sustainable and that plans will not deliver the required financial savings	2175	FIPC
A401ii	Trust governance systems are not sufficiently embedded which may reduce the means by which executive directors can be held to account for delivery of sound strategies, effective risk management and service quality.	4168	AC

BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee(s)
A403	Final business cases in relation to the Acute Care Reconfiguration Phase II at Longley Centre are not approved		FIPC
A404	The programmes for delivery are not developed or require additional resources not within plan and/or require significant re-prioritisation once developed	4121 4167	FIPC FIPC

Key:

AC	Audit Committee
FIPC	Finance, Information & Performance Committee
QAC	Quality Assurance Committee
WODC	Workforce and Organisation Development Committee

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A1O1 I	Executive Lead: Executive Director - Nursing, Prof, Care Standards	Risk Rating:	Impact	Likelihood	Score
Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance).		Residual Risk (with current controls):	3	2	6
		Target Risk (after improved controls):	3	1	3

BAF Risk Review Date:
Last Review: 05/02/2019
Next Review: 07/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
A master action plan is in place in response to CQC Well Led Inspection (July 2018). Robust systems of governance are in place to provide oversight of action plan delivery and the effectiveness of the actions being taken.		Board receives quarterly assurance from QAC. Monthly updates to EDG from Clinical Operations Monthly exception reports are received by TMG Plans are monitored at each level of Governance within the existing Clinical Operations structure Where actions are not achieved to timescale, Clinical Operations and Corporate Services produce remedial action plans and escalate as appropriate	CQC Well Led inspection July 2018, outcome 'Requires Improvement' ('Good' in Caring, Effective and Responsive) Wainwright Crescent CQC inspection December 2018 - rated 'Good' in all domains Clover Group (General Practice) CQC Announced Inspection 25th Sept 17. Final Report received in December '17 = Rated Good in all five domains & population groups. Clover City Practice inspected in November 2017. Final Report received December '17 = Rated Good in all five domains & population groups. Quarterly CQC Formal	Safety and Well-led domains rated as 'Requires Improvement' in the 2018 CQC inspection. Gaps identified around the application of policies in practice, seclusion facilities, staffing on inpatient wards and access and responsiveness of the Single Point of Access Service.	Limited

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 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	Negative Assurance OR Gaps in Assurance	Assurance Rating
			Engagement meetings Bi-monthly CQC 'Insight' Reports bring together intelligence about the Trust's performance from a range of external data sources such as MHMDS		

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A1O1 II Executive Lead: Executive Medical Director Inability to provide assurance regarding improvement in the quality of patient care.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	2	6	Last Review: 05/02/2019
	Target Risk (after improved controls):	3	1	3	Next Review: 07/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Quality Improvement and Assurance (QI&A) Strategy in place, which covers experience, effectiveness and safety, together with appropriate resources to implement.		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 which include progress on quality improvement projects. Quarterly assurance reports from Service User Safety Group provided to QAC. Quarterly assurance reports from Service User Engagement Group provided to QAC.	Annual Quality Report. CQC inspection report October 2018.	CQC rated as 'Requires Improvement' overall and within the 'Safe' and 'Well-Led' domains.	Limited
Quality schedule in place as part of national contract with NHS Sheffield CCG.		Targets within the Quality Schedule are incorporated into relevant quarterly assurance reports to QAC.	Quality is monitored by NHS Sheffield CCG via quarterly Quality Performance Reviews. Any issues are escalated to the monthly	Grading of serious incident investigation reports does not always meet the CCG target.	Moderate

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 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	Negative Assurance OR Gaps in Assurance	Assurance Rating
		Quarterly Impact Assessment (QIA) assurance reports to QAC. All CIP QIAs considered by Clinical/Corporate panel and signed off by EDG.	Contract Monitoring Group and/or Contract Monitoring Board.		
Service user and carer feedback is captured through various mechanisms, monitored through the Quality Assurance Committee.	Lack of systematic approach to dissemination of learning from feedback.	Service User Engagement group monitors performance in service user and carer feedback. Quality Assurance Committee monitors performance in formal and informal complaints and compliments.	360 Assurance audit reports on service user engagement and service user experience. (Limited assurance provided for service user experience. Significant assurance provided for service user engagement).	Quarterly and annual complaints reports provide limited assurance.	Limited
Service User Engagement and Experience Strategy is in place together with the appropriate resources to implement.	Improvements required in the uptake of Friends and Family Test and Care Opinion and to adequately manage and learn from this feedback.	Service User Engagement Group monitors progress against strategy implementation plan. Quarterly Service User Engagement Group assurance reports (including FFT data) to QAC Quarterly complaints and compliments report to QAC	CQC Inspection Report - October 2018 Monthly national benchmarking data from FFT Continuous Care Opinion Feedback 360 Assurance given significant assurance on service user engagement.	Service user feedback is limited in volume.	Moderate
Service users involved in Microsystem projects within teams.		Quarterly assurance reports from Clinical Effectiveness			Significant

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 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	Negative Assurance OR Gaps in Assurance	Assurance Rating
		to Quality Assurance Committee.			
Robust monitoring of CQUIN performance is in place via both operational and corporate governance structures.		Monthly CQUINs meeting monitors performance and agrees remedial actions where required. Quarterly reports to EDG and Quality Assurance Committee.	Quarterly reports from NHS Sheffield CCG regarding performance.	Under-performance on an number of CQUIN areas (physical health, alcohol & tobacco).	Moderate

Target Date: 28/02/2019 Responsible Person: Andrea Wilson

Action Details	Action Progress
Complaints reports format to be revised in order to improve the analysis of complaints across the Trust and strengthen the assurance provided by them regarding service user feedback.	Target date amended following discussions at Quality Assurance Committee.

Target Date: 31/03/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
Action plan developed to address the necessary improvements following the CQC inspection report. This is being monitored through agreed governance processes, with assurance provided to the Quality Assurance Committee and Board of Directors.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A1O2 I	Executive Lead: Executive Director - Nursing, Prof, Care Standards
Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.	

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

BAF Risk Review Date:	
Last Review:	07/01/2019
Next Review:	06/02/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Monthly Safer Staffing Group Monthly E Rostering Check & Challenge Group overseeing e-rostering performance management. Monthly Bank, Agency & E-Rostering Steering Group.	Directorate/Care Network level understanding of e -rostering & thus holding to account. Comprehensive Ward & Team level Workforce Profile (AFE review, recruitment, retention, turnover, vacancies, skill mix, age, gender, ethnicity etc.) Lack of reportable data from the NHSi Cohort 2 Recruitment & Retention Project (due to complete March 2019) compromising delivery of a measureable recruitment & retention plan. Full delivery of the National Quality Board (NQB) Improvement Resources for Mental Health & Learning Disability Services (January 2018). Full delivery of the NHSi Developing Workforce Safeguards (October 2018).	Monthly Safer Staffing Reports to EDG & BoD. NHSi Good Rostering Guidance Benchmarking Review undertaken & associated action plan completed May '18 Monthly E-Rostering Operational Performance Report reviewed at Care Network Governance meetings.	CQC Well Led Inspection (July 2018) Acute Care Wards received a regulatory breach in respect of staffing levels and an overall rating of Requires Improvement.	EDG & Board Reports do not yet include Patient Acuity & Dependency (Safe Care) or experience measures.	Limited

BOARD ASSURANCE FRAMEWORK 2018/19

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Executive and Board lead for E-Rostering is the Director of HR.		E-Rostering Group reports to Effective Staffing Group which reports to WODC.			Moderate

Target Date: 31/03/2019 Responsible Person: Caroline Parry

Action Details	Action Progress
Member of Cohort 2 NHSi Recruitment & Retention Programme to improve RN recruitment & retention rates. Action Plan submitted to NHSi (Feb 2018) delivery in progress	Report to be provided to Workforce planning group 12th February 2019.

Target Date: 31/03/2019 Responsible Person: Deborah Horne

Action Details	Action Progress
AFE review undertaken with Finance and Care Networks to address current reliance on agency and bank. (Excluding Forest Lodge, Forest Close and Buckwood View) Upon completion of review business cases will be submitted for funding gaps.	

Target Date: 28/02/2019 Responsible Person: Dean Wilson

Action Details	Action Progress
Clarify roles and responsibilities for the delivery of the NQB improvement resources and NHSi developing workforce safeguards.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A1O2 II Executive Lead: Executive Medical Director Inability to provide assurance regarding improvement in the safety of patient care.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	4	2	8	Last Review: 22/02/2019
	Target Risk (after improved controls):	2	2	4	Next Review: 24/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Patient Safety Improvement approach refreshed for 2018/19.		Quarterly assurance reports from the Service User Safety Group to the Quality Assurance Committee. Quarterly learning events take place within clinical operations. Safety huddles in operation. Annual safer care event.	CQC inspection report (October 18).	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. Quarterly learning events take place within Clinical Operations.	Bi-annual patient safety incident data from National Reporting Learning System (NRLS).		Significant
Lessons learned from investigations/reviews of care/mortality reviews are shared		Connect Learning events Staff debriefs	CCG reviews on serious incident investigation reports.	'Should do' gap identified by CQC around inconsistency of learning	Moderate

BOARD ASSURANCE FRAMEWORK 2018/19

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
across the Trust in a variety of ways.		Clinical operations governance meeting minutes. Quarterly incident management report Quarterly mortality report Structured Judgement Reviews flowchart	HM Coroner reviews of care provision during inquests. Serious Case Reviews, Child Death Overviews and domestic homicide reviews. CQC inspections (report October 2018	lessons.	
Appropriate training is in place for staff to ensure they are practising safely.		Training compliance rates Suite of training on offer to staff to support ongoing development.	CQC Inspections. Internal audit reports.		Significant

Target Date: 31/03/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
● Action plan developed to address the necessary improvements following the CQC inspection report. This is being monitored through agreed governance processes, with assurance provided to the Quality Assurance Committee and Board of Directors.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A1O4 II	Executive Lead: Executive Director - Operational Delivery
Failure to produce a citywide dementia strategy could impact on the coordination of citywide commissioning for dementia services.	

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

BAF Risk Review Date:
Last Review: 27/02/2019
Next Review: 29/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Joint lead for city-wide dementia strategy with LA and NHSSCCG with project time provided by SHSC.	City-wide dementia strategy to support the future of Trust services at Woodland View, Birch Avenue and the Memory Service not yet in place. Due end 2018/19.		Monthly report to MH & LD Delivery Board		Moderate

Target Date: 31/03/2019 Responsible Person: Clive Clarke

Action Details	Action Progress
Transformation project addressing the lack of a city-wide dementia strategy.	Following Board Development Session on 9/1/19, the Trust's response on the draft strategy was submitted. ---------- Draft strategy published Dec 2018 and currently subject to citywide consultation. Board development session on 9/1/19 to discuss the draft strategy and provide Board response as part of consultation process

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A2O2 Executive Lead: Director Of Human Resources	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
There is a risk that the Trust does not identify and develop new roles to meet current and future workforce needs.	Residual Risk (with current controls):	4	2	8	Last Review: 06/03/2019
	Target Risk (after improved controls):	2	2	4	Next Review: 05/04/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Effective Staffing Group oversees Workforce Planning Group, Medical Staffing Group, Bank Staffing Group, Agency and Off Payroll Group, Safer Staffing Group, E-Rostering Group.	Effective staffing group has not met regularly and therefore its remit and TOR to be reviewed.	Workforce In-Year monitoring return to NHS Improvement Monthly report to NHS Improvement on nursing agency/bank usage.	Contract monitoring report to NHS Sheffield CCG. IA 360 assurance report on workforce planning 2018-limited assurance. IA 360 assurance report on workforce utilisation January 2019 - significant assurance	Lack of formalised governance framework for workforce planning Links not explicit to Trust operational plans	Limited
3 year Workforce Strategy approved by Board Sept 17. Workforce Strategy Delivery Plan in place.		Quarterly delivery plan progress reports to WODC.			Moderate

Target Date: 31/03/2019 Responsible Person: Karen Dickinson

Action Details	Action Progress
● Development of a Trust-Wide Workforce Plan due for completion end March 2019	Workforce Planning session did not take place but meetings have taken place with professional leads. A task and finish group has been set up to complete the workforce plan. ---------- Workforce planning session with Clinical Managers to inform the Trust Workforce plan scheduled for 20th November 2018

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

Target Date: 31/03/2019	Responsible Person: Guy Hollingsworth
Action Details	**Action Progress**
● Effective processes between HR and Finance to be agreed regarding the reconciliation of information between HR and Finance systems.	Regular reconciliation processes in place but vulnerable to gaps in staffing. To date ESR has not held establishment data. Work is underway to make this happen. On track to be completed by March 19 deadline. It will require an enhanced reconciliation process between HR and Finance to maintain it. This has workload implications for both departments. ---------- Initial meetings with Guy Hollingsworth and Finance. Temporary resource in place from December to support updating data in ESR (supervisor field in readiness for self service)

Target Date: 31/07/2019	Responsible Person: Dean Wilson
Action Details	**Action Progress**
● Review of effective staffing group TOR and remit as required by IA audit report.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A2O3 Executive Lead: Director Of Human Resources Values not embedded consistently across the Trust which may impact on employee relations.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	3	9	Last Review: 06/03/2019
	Target Risk (after improved controls):	2	2	4	Next Review: 05/04/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Case Review process in place to support continuous improvement and embedding of Trust values.	Legal briefing "Lessons Learned" yet to take place. Scheduled March 2019	Disciplinary Policy updated 2018 and in place. Microsystems in place to support Employee relations processes.			Moderate
Listening Into Action model Pulse check to be launched 11/3/19 (Staff Engagement)		Will report to EDG			Moderate
Regular reporting on workforce metrics and activity (for example casework, sickness, staff survey, training, PDR compliance and wellbeing) to The Clinical Operations, Performance and Governance meetings (or SMTs for Corporate) to identify hotspots or areas for specific action.		Clinical Operation, Performance and Governance meeting report (reports to SMT for Corporate). Performance report to WODC	staff survey 2018	Health and Wellbeing, Morale, Quality of Appraisals, safety, culture and staff engagement	Limited
Organisation Development leadership resource agreed					Moderate

Target Date: 01/04/2019 Responsible Person: Dean Wilson	
Action Details	Action Progress
Appointment of the director of OD	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A2O4 Executive Lead: Director Of Human Resources Risk of reduced productivity and service quality as a result of low morale and motivation	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	3	9	Last Review: 06/03/2019
	Target Risk (after improved controls):	2	2	4	Next Review: 05/04/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
A range of support mechanisms and services in place for staff (including workplace wellbeing, Schwartz rounds, Physio Med, Leadership Engagement Network)			Staff Survey 2017 (reported 2018)	Reduced motivation, increased stress, perception of lack of equal opportunities, staff working creased hours.	Limited
A CQUIN for health and wellbeing in place.		Progress against CQUIN reported to WODC quarterly. Health and Wellbeing group bi-monthly review of progress against actions to achieve CQUINS funding.	Monthly contract management meeting with CCG.		Significant
Reward and benefits schemes in place (salary sacrifice schemes)		Take up and usage reported to EDG annually			Full Assurance
Workforce Strategy (approved 2017) in place which identifies how to manage change effectively		Reports to WOD (quarterly) and TOG	Dean Royles review (December 2018)	Identified changes required to organisational Change processes and support. Support for staff in change Partnership work with staff side	Moderate

Target Date: 31/01/2019 Responsible Person: Karen Dickinson	
Action Details	Action Progress
Review and refresh of Leadership Engagement Network (LEN).	Review Dec 2018 instigated by Chief Executive following staff feedback.

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

	Facilitator identified to take forward future meetings ---------- Plan to roll out leadership development in development LEN schedule of monthly events

Target Date: 31/01/2019	Responsible Person: Dean Wilson
Action Details	**Action Progress**
To explore options used in other NHS organisations that have been shown to improve staff survey results based on an organisational development approach.	Review complete and reported to EDG. Listening into action engaged and implementation to take place

Target Date: 31/03/2019	Responsible Person: Dean Wilson
Action Details	**Action Progress**
Review what action is already being undertaken that should support improvements in the areas highlighted in the staff survey and where there are gaps in specific actions.	Discussed at TOG and led by HRBP (Matrix with Senior Operational managers

Target Date: 31/03/2019	Responsible Person: Dean Wilson
Action Details	**Action Progress**
To look at any hot spots highlighted in survey results, for example specific services that may require more detailed attention.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A3O2 II Executive Lead: Executive Director - Operational Delivery There is a risk to implementation of the Community Wellbeing Strategy due to capacity issues within the Trust and from competing Trust priorities.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	3	9	Last Review: 02/01/2019
	Target Risk (after improved controls):	2	3	6	Next Review: 14/02/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Both strategic and planning capacity identified and leading on the work (IAPT and Employment).		Update report to EDG bi-monthly		Social Prescribing and Community Hubs work still in development	Moderate
Collaborative working with Primary Care		Quarterly reporting to Joint Executive Board (JEB)			Moderate
Assistant Director Community Wellbeing appointed to support planning and delivery (fixed term appointment) in post.					Moderate

Target Date: 31/03/2019 Responsible Person: Fiona Goudie	
Action Details	Action Progress
● Board Development Session to be scheduled to expand the vision and provide clarity of direction from a Trust perspective	Board Development Session date not yet secured, but to take place within the near future. Timescale extended by 2 months. ---------- A planning session to take place on 26/9/18 for the Development Session.

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A3O3 Executive Lead: Executive Director - Operational Delivery Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
	Residual Risk (with current controls):	3	4	12	Last Review:	27/02/2019
	Target Risk (after improved controls):	2	2	4	Next Review:	29/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Review of the reconfiguration process relating to the Trust's Change Management and HR Policies undertaken by an independent source (Dean Royles) in order to identify lessons learned and good practice. Terms of Reference of the review agreed with Trade Unions.		External report received which showed Trust policies were adhered to.	Dean Royles report completed and received.	Trust's Change Management Policy to be reviewed.	Moderate
Planned external review to take place in 2019 once the service has fully embedded to provide assurance that the reconfiguration has achieved its stated objectives. External reviewer agreed (Professor Scott Weich).					Moderate
Governance structure provides assurance of oversight of all major change programmes within clinical operations including assurance that sufficient capacity and capability is in place to ensure delivery. This includes Change & Improvement Group (director level sponsorship), Project Charter & Working Group, Care Network Quadrant and		Monthly exception reports to EDG of deviations from plan, making recommendations for decision making and ensuring scheme 'fit' with overall objectives. Reports to Clinical Operations & Change			Significant

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 3. FUTURE SERVICES

Strategic Objective: 3.3 Provide Effective Community Care And Treatment

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Leadership meetings.		Improvement Meeting Monthly reporting to Care Network Clinical Operations & Performance Governance Meeting.			

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A3O3 II Executive Lead: Executive Director - Operational Delivery Risk to the timely completion of the Decisions Unit (formerly known as PDU) due to a lack of clinical and project capacity	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	4	2	8	Last Review: 27/02/2019
	Target Risk (after improved controls):	2	2	4	Next Review: 29/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Project team established and in place		Paper to EDG 5/7/18 to seek approval of governance structure and project team			Significant
Design approved and signed off by EDG on 5/7/18.					Significant
Tendering process complete and successful contractor in place.					Significant
Contractor agreed and on site from 5th November 2018. Unit to open on 4/3/19					Significant

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A4O1 I	Executive Lead: Executive Director Of Finance	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
The Trust will not continue to be financially sustainabile and that plans will not deliver the required financial savings		Residual Risk (with current controls):	5	2	10	Last Review:	14/01/2019
		Target Risk (after improved controls):	5	2	10	Next Review:	13/02/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
5 year long term financial model Financial planning, including control total consideration and CIP plans Strong financial governance and management in place at Trust , divisional and service level and with key partners Risk share in place with commissioners within Sheffield	Effectiveness of budget management and controls at service and team level, particulalry effective establishment control and ownership	Monthly finance report to Board, FIPC and EDG. Summary reports to TOG, EDG	NHSI monitoring against Single Oversight Framework NHSI quarterly review meeting (QRM) & letter Head of Internal Audit Opinion. and significant positive assurance re financial audits	Financing of capital plans TBC. Loan not yet secured. CIP planning for 19/20	Moderate

Target Date: 31/03/2019 Responsible Person: James Sabin

Action Details	Action Progress
Refresh financial modelling and plans re revenue and capital consequences of business case developed in 2018/19 (e.g. ACR2 FBC, Digitel BCs)	This has commenced being refreshed based on AP08 intel and current performance but we are awaiting the final qtr 3 position statement to add in one final update. This will be fed into the updated 2019/20 operating plan due for submission in February 2019 in draft form and early April in final form. ---------- Work underway but will be reflective of M7 position and updated planning and bonus payments re over performance for 2018/19.

Target Date: 31/03/2019 Responsible Person: James Sabin

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 4. VALUE FOR MONEY

Strategic Objective: 4.1 We Will Improve The Productivity And Efficiency Of Our Services

Action Details	Action Progress
Review budget setting principles to support good financial management, effective establishment control and the appropriate funded staffing levels. Support freeing up resources for Clinical directorate investments, where recurrent investment is deemed needed and not commissioner funded.	The financial plan continues to be developed following the issue of the guidance and linked to on-going contract negotiations. This will be progressed through February in draft form and right through to late March re final plans. ---------- Action on-going as part of budget setting and financial planning for 19/20.

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A4O1 II Executive Lead: Chief Executive

Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation.

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	4	12
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:
Last Review: 26/02/2019
Next Review: 28/03/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Governance structure in place from Board to operational group level	Review of some Board Committee Terms of Reference outstanding	Committee/Group minutes and reports to Board Committees Significant issues report to Board from each Board Committee Monthly Clinical Operations, Performance & Governance Meeting reports to EDG	Annual Head of Audit Opinion (Moderate for 17/18) Internal audit reports Quarterly NHS Improvement Review Meetings.	Embeddedness of assurance systems and processes	Moderate
Risk Management Strategy 2017 in place.	Risk Management Strategy requires refreshing by year end 2018/2019.	Annual Governance Statement Corporate Governance Statement	360 Internal Audit of Operational Risk Management (Jan 18) - limited assurance - all actions now complete and signed off by IA.		Limited
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.	Internal Audit 360 Assurance Policy Management report Sept 17 provides limited assurance. Follow up report (July 2018) shows progress	Electronic policy management system not fully embedded. 'Must Do' revisions to	Limited

BOARD ASSURANCE FRAMEWORK 2018/19

AIM: 4. VALUE FOR MONEY | Strategic Objective: 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	Negative Assurance OR Gaps in Assurance	Assurance Rating
			made. CQC Well-Led Inspection (July 2018) identifies policies as a must-be-done (review/updating/reflecting national guidance and best practice).	internal policy governance partially complete.	

Target Date: 13/03/2019 Responsible Person: Margaret Saunders

Action Details	Action Progress
● Committee Terms of Reference are being reviewed for consistency and clarity.	WODC Terms of Reference taken to January '19 committee. Further revisions made and final ToRs to be presented to Board on 13/3/19 therefore timescale extended to this date. ---------- WODC Draft ToRs presented to meeting on 31/1/19. Timescale extended by 3 months.

Target Date: 31/03/2019 Responsible Person: Margaret Saunders

Action Details	Action Progress
● Action plan prepared with recommendations from 360 Assurance Trust Committee Governance consultancy review follow up.	All actions completed with the exception of the review of ToR for EDG. ---------- Four action now completed. Outstanding actions progressing. Timescale amended accordingly (extended by 3 months).

Target Date: 31/03/2019 Responsible Person: Margaret Saunders

BOARD ASSURANCE FRAMEWORK 2018/19

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

Action Details	Action Progress
Process commenced to review and align all Terms of Reference (ToRs) and Work Programmes of Operational Groups providing assurance to Board Committees. Commenced with the Quality Assurance Committee (QAC), Finance, Investment & Performance Committee (FIPC) and Workforce & Organisational Development Committee (WODC) to follow.	Work currently focusing on WODC. FIPC remains outstanding. Timescale extended to year end. ---------- Work continues. However, the timescale has been amended to reflect the scope of work and changes to the remit and work plans of committees.

Target Date: 31/03/2019 Responsible Person: Margaret Saunders

Action Details	Action Progress
Review risk register governance arrangements for corporate directorates to complement arrangements agreed within care networks.	Governance arrangements agreed with Facilities and HR. Still awaiting information from Finance and IMST. Timescale extended by a further one month. ---------- Work progressing. Timescale extended by one month.

Target Date: 31/03/2019 Responsible Person: Margaret Saunders

Action Details	Action Progress
Action plan agreed to meet CQC 'Must Do' requirements regarding policies. Action plan is reviewed by Policy Governance Group.	Action plan is partially complete. All outstanding actions to be completed by 31/3/19.

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A4O3 Executive Lead: Executive Director Of Finance Final Business cases in relation to the Acute Care Reconfiguration phase 2 at Longley Centre are not approved	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	4	3	12	Last Review: 21/09/2018
	Target Risk (after improved controls):	4	2	8	Next Review: 21/10/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Governance and reporting arrangements in place through EDG via TOG/BPG.		TOG minutes (monthly) and Checkpoint Reports and Status Reports.			Significant
Stakeholder meetings held with all relevant community and inpatient service managers. Outcomes have informed the development of the plan to deliver the estates strategy.				Engagement is ongoing and plans being developed (for medium-term and long-term), but not yet finalised.	Moderate
5 Case model / compliant business case developed, Affordability of Plan		ACR 2 OBC		External Sign-off of OBC and Loan approved	Moderate

Target Date: 31/03/2019 Responsible Person: James Sabin	
Action Details	Action Progress
● FBC Financing - Loan facilities to be put in place prior to FBC	The position remains relatively unchanged. This has been approved in principle by the ITFF/(PWLB) but is currently in the national queue with HMT for access to capital funds. We are advised we remain a priority in the upper quartile. Overall loan needs have reduced from provisional £14m+ but as yet we have not reduced our ask. This forms part of the overall review and updated assessment of the ACR business case linked to our improved financial performance. ---------- The FT Financing Facility (PWLB) review the case at an August meeting and this was supported in principle. This is now being progressed for recommendation to HMT. Feedback to date verbal and chasing formal documented response. Delays are anticipated due to national CAPEX funding shortfalls nationally.

BOARD ASSURANCE FRAMEWORK 2018/19

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

Target Date: 31/03/2019	Responsible Person: James Sabin
Action Details	Action Progress
NHS Improvement due diligence on OBC -Liaise with NHS I to ensure prompt approval Appriase DoF and FIPC of any ammendments for information / Approval as appropriate	ICS Capital Bid Unsuccessful. This has consequences for all other capital requirements due to national Capex shortfalls and restrictions. This could potentially add a further 9 months to any process re consideration. Autumn 2019 potentially next available window. Impact being discussed with NHSi and alternative options being explored. ---------- Dialog with NHSi has been escalated to regional level. Phone call discussions have been held at Director level and NHSi position now formally communicated to SHSC in writing. There will be a delay to the NHSi approval process. Significant transaction review and approval will not be considered until after the Autumn ACS/ICS capital programme allocations and prioritisation have been agreed. (process not even developed and clear yet) even if we are seeking funding. Even if loan secured, delays expected. At present, updating models to reflect quarter 2 updated cash position which may reduce borrowing need.

Target Date: 31/01/2019	Responsible Person: James Sabin
Action Details	Action Progress
Reassess requirement for NHSi approval as a Significant Transaction based on updated financials.	

Target Date: 31/03/2019	Responsible Person: James Sabin
Action Details	Action Progress
Update Loan requirement based on updated financial and updated wider capital plan. Linked to updated Operating Plan for 2019/20	

Target Date: 31/03/2019	Responsible Person: James Sabin
Action Details	Action Progress
Consider alternative options open to Trust with regards to progressing ACR without breaching NHSi regulations. This includes multiple back up options.	

BOARD ASSURANCE FRAMEWORK 2018/19

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

Risk Ref: A4O4 Executive Lead: Executive Director Of Finance

The programmes for delivery are not developed or require additional resources not within plan and/or require significant reprioritisation once developed

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	4	16
Target Risk (after improved controls):	2	3	6

BAF Risk Review Date:
Last Review: 14/01/2019
Next Review: 13/02/2019

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Compliance with IT Strategy (dynamic).		Data and Information Governance Board (DIGB) Business Planning Group (BPG). Updated IT strategy approved by BoD May 2018.	Auditors (specific audits) and NHS England Digital Maturity Toolkit.		Significant
Business planning processes, including relevant resource requirements included in business cases	Portfolio Management Office (PMO) capabilitites / maturity re overall oversight of all portfolios, projects and programmes and associated control and decsion making			PMO assurance reporting	Moderate

Target Date: 28/02/2019 Responsible Person: Nicola Haywood-Alexander

Action Details	Action Progress
● Terms of reference for governance groups to be reviewed following the clinical restructure in Q1.	PMO function transferred to Director of Quality (November 2018). Support for governance meetings currently in transition. Revised governance arrangements remain under discussion. Timescale extended by two months. ---------- PMO and governance review ongoing. Timescale extended by 3 months to allow agreement and supported change within IMST, PMO and clinical areas.

Target Date: 30/04/2019 Responsible Person: Nicola Haywood-Alexander

BOARD ASSURANCE FRAMEWORK 2018/19

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

Action Details	Action Progress
Intergrated Healthcare Systems Full Business Case (FBC)	The process of approval to begin in February 2019. Final approval expected in April 2019 at Board of Directors therefore timescale extended by 2 months to reflect this. NHS Digital and DoH agreed delay to funding gateway to May 2019. ---------- FBC delay due to extensive work and clarification required for Fast-Follower submission and assurance. FBC requirement separated into management FBC deliveries in accordance to Fast-Follower agreed schedule. Therefore target date extended for first FBC for PAS by 5 months.

Target Date: 31/03/2019 Responsible Person: Nicola Haywood-Alexander

Action Details	Action Progress
Performance Management and business intelligence FBC approved by March 2019	Reviewed - no update to provide as at 24/9/18

Target Date: 31/03/2019 Responsible Person: Nicola Haywood-Alexander

Action Details	Action Progress
Contact management solution business case to be produced.	