Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

OPEN BOARD OF DIRECTORS
11th January 2017

BoD: 11.01.17
Item: 8

TITLE OF PAPER	Board Risk Profile
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	Discuss and approve the Board Risk Profile Agree to continue to receive monthly updates

OUTCOME	To ensure the Board of Directors is fully informed of the high level risks that are prevalent within the Trust
TIMETABLE FOR DECISION	The Risk Profile will be presented to the Board of Directors on a monthly basis
BAF OBJECTIVE No and TITLE	Strategic Aim 5 – financially viable, effective and well governed organisation. Individual BAF references are highlighted within each risk.
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports on Risk Management Corporate Risk Register Board Assurance Framework Directorate Risk Registers
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES ETC	Board Assurance Framework links to strategic aims and objectives, corporate (organisational) risk register, directorate risk registers. NHS Improvement's Provider Licence NHS Improvement's Risk Assessment Framework NHS Improvement's Well-led Framework
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Implications of individual risks outlined on the Risk Profile
CONSIDERATION OF LEGAL ISSUES	Compliance with NHS Improvement's Provider Licence and Risk assessment Framework.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	29th December 2016

Sheffield City Council

Sheffield Health and Social Care NHS
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SUMMARY REPORT

BoD: 11.01.17
Item: 8

Report to: Open Board of Directors

Date: 11th January 2017

Subject: Board Risk Profile

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

Prepared by: Sam Stoddart, Deputy Board Secretary

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1. Purpose

The attached report is the Board Risk Profile produced using the high level risks currently recorded on the Trust's Corporate Risk Register. This report is provided to enable greater awareness and understanding at Board level of the major risks facing the organisation and for the Board to challenge the effectiveness of the controls in place to mitigate these risks.

2. Summary

The corporate risk register records the risks that underlie the strategic, overarching risks that are captured on the Board Assurance Framework (BAF); the operational risks that the Trust faces on a day-to-day basis. Risks that cannot be controlled within a single directorate, or that affect more than one directorate, are recorded on the corporate risk register.

The risks on the Risk Profile have been graded using the Trusts 5 x 5 risk matrix shown below. Only those risks rated 12 or above are shown on the Board Risk Profile of which there are currently 10.

Consequence	Likelihood				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Negligible (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Once completed, actions are no longer shown on the report. Therefore all actions are either outstanding or on-going.

Since this report was last presented to the Board of Directors in December 2016 the following amendment have been made:

Risk No	Description	New	Risk Description updated	Risk Rating Amended	Controls Updated	Actions Updated
3658	ICT System Compliance	x	✓	x	x	✓
3617	Hurlfield View	✓ (moved from confidential register)	x	x	x	✓
2196	Section 75	x	✓	x	✓	✓
2175	Cost improvements	x	✓	x	✓	✓
3611	Wainwright Crescent	✓ (moved from confidential register)	x	x	✓	✓
2310	Retraction of provider services	x	x	✓	x	✓
3439	Transformation Agenda Clover Group	x	✓	x	✓	✓
3679	Risk to harm from ligatures	✓ approved by EDG on 22/12/16				
2163	Statutory and mandatory training	x	x	x	✓	✓
3327	Clinical Audit	x	x	x	✓	✓

Please note that risk 3658 has remained as a single risk following the clarification of the risk description by the Director of ICT.

3. Next Steps

- New corporate risks will be discussed with risk leads, to ensure accurate recording of risks, controls and actions, prior to inclusion on the corporate register, where EDG agrees appropriate for inclusion;
- The Director of Corporate Governance will maintain the corporate risk register on the Board's behalf;
- Following discussion at EDG regarding directorate escalated risks, additional risks may be added to the Profile, prior to presentation at the next Board meeting;
- The Executive Directors' Group (EDG) will review the Risk Profile prior to Board meetings;
- The Corporate Risk Register will continue to be presented to the EDG in its entirety on a quarterly basis. The risks relevant and rated 12 and above will be presented to Audit Committee, QAC, FIC and WODC at least four times a year.

4. Required Actions

The Board of Directors is asked to:

- Discuss and approve the Board Risk Profile;
- Agree to continue to receive monthly updates.

5. Monitoring Arrangements

The corporate risk register will be maintained by the Director of Corporate Governance. EDG and the Board of Directors will receive and monitor high level risks on a monthly basis. EDG, the Quality Assurance Committee and the Audit Committee will receive and review the corporate risk register on a quarterly basis.

6. Contact Details

For further information, please contact:

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PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
3658 4.1	Executive Director Of Finance	Under investment in Microsoft licences by the Trust will lead to non-compliant and insecure ICT systems.	4 Major	3 Possible	12	• SNOW Software Asset Management has been implemented. • SoftCat engaged in delivering Licence Strategy for the Trust.	Procurement through a third party supplier (SoftCat) (agreed by Board Dec 2016).	31/01/2017
3617 4.1	Executive Director - Operation	Risk re loss of business, income and potential reputational damage due to SHSC serving notice on SCC in respect of the provision of service at Hurlfield View from 31 March 2017. This will also have a detrimental effect on dementia care pathway and may result in increase in admissions to acute hospital beds.	3 Moderate	4 Likely	12	• Notice served on SCC. • Hurlfield View redesigned further to contract award. • Ongoing dialogue with LA at directorate and executive level. • City Council and SHSC working together to oversee closure. • Working with Staffside to ensure smooth handover of care.	Staff informed w/c 17/10/16. Working with HR and Unions re exit plan, staff support and redeployment. Discussions ongoing with SCC re supporting move to closure. Consider step-up and step-down beds as part of a joint workshop between SHSC and CCG to review the dementia care pathway.	31/03/2017 31/03/2017 28/02/2017
2196 2.1	Deputy Chief	Risk of uncertainty regarding new vehicle to under pin the partnership working following the end of the Section 75 agreement on 31st October 2016.	4 Major	3 Possible	12	• GAP IN CONTROL: no replacement mechanism to underpin funding and governance arrangements. • Outline Plan agreed with the Council and by the Board in January 2014.	Further discussions required regarding some elements e.g. supply/secondment of the agreement.	31/03/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
	Executive					• Additional budgetary provision allocated by Council to address elements of financial challenges. • Plan significantly reduces risk to direct care provision and assessment and care management support services. • Emphasis on achieving value for money within care purchasing and re-design of the model for care delivery.		
2175 4.1	Executive Director Of Finance	Inability to deliver required financial savings for 2016/2017. Failure to fully deliver recurrent CIP and disinvestment plans in 2015/16 led to a target carry-forward of £3.368m, contributing to the total savings target for 2016/17 of £12.459m. As of October 2016 plans are in place to deliver in-year savings of £11.662m (94% of plan) and recurrent full-year savings of £10.615m (85% of plan). This represents a significant risk to the delivery of our 2016/17 financial targets and to our ability to develop robust financial plans from 2017/18 onwards. At present the Trust is forecasting achievement of its control total and the shortfall is planned to be recovered and/or mitigated during 2016/17. Resulting	4 Major	3 Possible	12	• CIPs and disinvestments for 2016/2017 are being managed and monitored by EDG. All clinical CIP plans are quality impact assessed (QIA) and reviewed and approved by the CIP and Disinvestment Working Group. • The Director of Finance is managing directorate performance via the Trust's performance framework which ranks directorates into tiers based on forecast outturn position and CIP/disinvestment gaps. Directorates ranked in the lowest tier will be required to produce and implement a financial recovery plan which is being monitored via monthly meetings with the Director of Finance and Executive Directors Group.	A number of new actions are emerging in relation to the delivery of the 2017/18 - 2018/19 financial plan and specifically in relation to the CIP requirement and delivery. A number of papers have started to go via EDG for formal support with regards to agreed actions. These include: - the full creative ideas list for potential saving opportunities. Nothing off the table. - engagement and request for contributions from all levels of our organisation and stakeholders. - the development of a communication strategy covering the financial challenge and communications required in relation to achieve an organisation-wide collaborative approach to CIP delivery. - alongside clinical transformation plans and the collaborative work being carried out with the Local Authority and CCG.	31/01/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
		residual risk remains low. The risk primarily relates to the inability to deliver required financial savings for 2017/18 to 2018/19.				• Areas where CIP gaps and concerns remain are in relation to LD (non-health side) and Human Resources. These are being monitored via the above performance framework. • Reports on the progress and performance of CIP and Disinvestment schemes are routed via EDG monthly and FIC quarterly. • All outstanding CIP and disinvestment gaps are carried forward in the directorates to which they relate within the financial planning for 2017/18 - 2018/19. • The 2016/17 CIP is still being proactively managed and pursued at a level which is mitigated by reserves. The focus and risk is now very much shifting to 2017/18 - 2018/19. • Quarterly review of all CIP and disinvestment plans and to explore alternatives for consideration including the benefits of any productivity work undertaken. • Monthly performance management action is being taken in respect of all directorates reporting a forecast outturn overspend and/or a material CIP disinvestment gap. Process embedded and on-going.	The creation of a new working group (identified leads) on the exploratory options available to the Trust to meet its financial challenge. This shall incorporate full oversight of the CIP planning and delivery process and report to EDG. These include: - weekly/bi-monthly Trust CIP & Disinvestment Working Group meetings - weekly QIPP meetings with the CCG re joint working group. All CIP/Disinvestment plans will be subject to a QIA process via the CIP & Disinvestment Working Group.	31/01/2017 31/03/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
						• The CIP and Disinvestment Working Group is operating throughout the financial year supporting and capturing the schemes identified by directorates with the objective of ensuring these are robust and delivered, linking into the QIA sign-off process where required. Completed and on-going. • The CIP and Disinvestment Working Group has commenced planning and oversight in relation to the 2017/18 financial year. • The first draft CIP/Disinvestment plans are enclosed within the second iteration of the financial plan and are being evaluated. • Dedicated operational leads have been identified within existing established roles to take this work forward.		
3611 1.1	Executive Director -	The loss of the 3 step down beds (SCC commissioned) at Wainwright Crescent, with effect from 1/11/16 could have a detrimental effect on the acute care pathway, together with the potential to increase inpatient admissions and length of stay.	3 Moderate	5 Almost Certain	15	• Ongoing discussions with CCG regarding remaining 4 step-down beds and service configuration. • Ongoing discussions with SCC regarding future commissioning arrangements. • Financial recovery plan for loss of funding has been developed and agreed.	Fully implement the Financial Recovery Plan.	28/02/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
	Operation					• An impact assessment paper presented to December 2016 Board detailing issues and risks.		
2310 1.1	Executive Director - Operation	Risk to quality of care and staff morale due to the Local Authority intention to retract provider services (residential and supported living).	4 Major	5 Almost Certain	20	• LD Staffing Services Project Group established and can identify and respond to any immediate risks. • Quality of services monitored through internal SHSC processes, SCC contract monitoring and Housing Association quality assurance mechanisms. • Every effort to recruit to all vacancies including leavers and working with Flex Steering Group to improve pool of available, appropriate staff. • Regular staff communication and engagement to ensure staff are well informed, Soundings taken by local managers and fed back into project groups. • Gaps in staffing being monitored through incident reporting mechanisms. • Organisational Change Policy operational. • All remaining residential care staff have transferred to new employers under TUPE.	Continue to engage with staff and staff side on developments. Engage with new supported living providers to ensure smooth handover of Service Users and staff.	31/08/2017 31/08/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
3439 1.1	Executive Director - Operation	Due to the high turnover of staff within Clover and high usage of locum/agency staff there is a risk to the successful implementation of the transformation agenda as the service moves from the old to the new systems. High usage of temporary staff can impact on the quality of service provision and its delivery.	4 Major	4 Likely	16	• Organisational change process complete and transformation agenda being implemented within a 6-12 month timeframe, but in line with agreed tender funding levels. However, there is a challenge in delivering within the financial constraints. • Close monitoring at SMT with HR. • Staff continue to be supported through any organisational change. • Engagement of temporary staff - admin and reception, plus locum clinicians. • Continual staff engagement and communication to ensure staff are kept up to date. •	Further review planned at Joint Executive Board on 9th Jan 2017 (JEB currently holding the risk). Authorising additional staff overtime.	09/01/2017 31/03/2017
3679 1.4	Executive Director - Operation	Risk of harm to service users via ligatures	5 Catastrophic	3 Possible	15	• Service user individual risk assessments. • Annual formal ligature risk assessments. • Weekly Health and Safety checks. • Reviews following ligature incidents. • Ligature risk reduction policy and procedures.	As part of the service redesign ensuring that all environments meet the agreed the specification for reduced fixed ligature points. Ensure effective implementation of new observation policy. Create 3 reduced ligature-point bedrooms per acute ward including the fitting of sensor taps, anti-ligature ceilings, anti-ligature windows and fixed beds.	28/09/2017 31/03/2017 28/02/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
						• Management of equipment and estates work. • Clinical risk training. • Clinical practice including observations as directed by observation policy. • Risk identified at directorate level on risk register. • Design of new clinical environments. • Engagement in collaborative care planning with service users.		
2163 5.3	Director Of Human Resources	Risk of non-achievement of Trust's target for staff attending statutory and mandatory training.	3 Moderate	4 Likely	12	• The Trust has a standardised compliance report. This is now provided to directorates on a monthly basis. • Directorates have established Mandatory Training Leads within each senior management team. They are responsible for improving attendance and training compliance. There are targets set (and monitored) for each subject for each Directorate • An annual training needs analysis and training plan is developed which covers a wide range of training (not just mandatory training). This is co-ordinated with the City Council process.	E-assessments are to be developed for some repeat training. Team Compliance reports to be developed from the end of Feb 2017 via Business Intelligence. This time scale has slipped because QlikView is not able to access the required data. Revised approach to training and training compliance to be developed and agreed for Bank staff. Review of content of induction training. Further discussions with CCG on timescales for repeat training and new starters.	31/01/2017 28/02/2017 15/03/2017 28/02/2017 31/03/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
						• The Mandatory Training Steering Group (MTSG) co-ordinates actions on improving training delivery and recording between Education and Training, Directorate Leads and subject leads across the Trust. • Mandatory Training Steering Group oversees a regularly reviewed action plan and gap analysis. • Illustrative costs identified of the financial implications for the full achievment of currently identified mandatory training. • A trajectory for improved compliance per subject and per directorate has been agreed with the CCG. • Directorates performance manage compliance rates for own area and add to Directorate risk register where specific issues arise. • E-learning lead in place. This role includes the development and promotion of more e-learning packages. E-learning local leads have been recruited to support staff in completion. • Training Competencies Requirements (TCRs) have been revised on OLM and a revised process establishing for defining these for new roles.	Revised plan for Mental Health Act training following CQC inspection in November 2017.	28/02/2017

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
						• Sustainable delivery plan (from April 2017) agreed by EDG Dec 16. • Mandatory Training Compliance has been included in business planning process for all directorates 2017/18. • Further additional courses arranged to reach required compliance levels Jan to Apr 2017.		
3327 4.3	Medical Director	Inadequate clinical audit processes which inhibits the Organisation's understanding of compliance with National Clinical and regulatory Care Standards.	3 Moderate	4 Likely	12	• Clinical Audit policy developed. • Clinical Effectiveness Group established to drive and monitor progress of Priority Audit Programme. • Mechanisms in place for agreeing future audit priorities. • Agreed annual clinical audit programme in place with monthly monitoring by the Clinical Effectiveness Group and quarterly oversight by the Quality Assurance Committee and NHS Sheffield Clinical Commissioning Group. • NICE policy revised with 360 Assurance. • Medical Director re-emphasised with directortes the importance of attendance at the Clinical Effectiveness Group.	Medical Director currently overseeing progress of the Clinical Effectiveness Group. Clinical Audit Facilitator supporting progress of priority audits with directorates.	31/03/2017 31/03/2017