Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

OPEN BOARD OF DIRECTORS
8th February 2017

Item: 5

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	Margaret Saunders
Designation	Director of Corporate Governance (Board Secretary)
Date of Report	31 January 2017

Sheffield City Council

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SUMMARY REPORT

Report to: **Open Board of Directors**

Date: 8th February 2017

Subject: Board Risk Profile

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

Prepared by: Margaret Saunders Director of Corporate Governance **(**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 amendments have been made:

(i) Risk Numbers:

3658 – ICT Compliance has been re-assed and de-escalated to Directorate level.

3611 – Wainwright Crescent has been re-assed and de-escalated to Directorate level.

2310 - Retraction of Provider Services has been re-assed and de-escalated to Directorate level.

(ii)

Risk No	Description	New	Risk Description updated	Risk rating amended	Controls updated	Actions updated
3617	Hurlfield View	X	✓	X	X	X
2196	Section 75	X	X	X	X	X
2175	Cost Improvements	X	✓	X	✓	✓
3439	Transformation Agenda Clover Group	X	X	X	X	✓
3679	Risk of Harm from ligatures	X	X	X	X	X
2163	Statutory and mandatory training	X	X	X	X	X
3327	Clinical Audit	X	X	X	X	X

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, Quality Assurance Committee, Finance and Investment Committee and Workforce and OD Committee 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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Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

PUBLIC BOARD RISK PROFILE

Risk No. BAF Risk	Lead Director	Details of Risk	Consequence	Likelihood	Current Score	CONTROLS IN PLACE	ACTIONS	TARGET DATE
3617 4.1	Executive Director - Operation	Risk of reputational damage in respect of the potential closure of Hurlfield View on 31 March 2017 with the possibility of the closure having a detrimental impact on the dementia care pathway.	3 Moderate	4 Likely	12	• Ongoing dialogue with SCC and SCCG at directorate and executive level. • SCC and SHSC working together to oversee closure. • Working with Staffside to ensure smooth handover of care.	Consider step-up and step-down beds as part of a joint workshop between SHSC and SCCG to review the dementia care pathway. Staff informed w/c 17/10/16. Working with HR and Unions re exit plan, staff support and redeployment. Discussions ongoing with SCC and SCCG re supporting move to closure.	28/02/2017 31/03/2017 31/03/2017
2196 3.3	Deputy Chief Executive	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 2017. • 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.	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
2175 4.1	Executive Director Of Finance	Failure to deliver required levels of CIP and disinvestments.	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. • Trust business planning cycle and processes. • Task and finish group establish to ensure processes are in place to mitigate loss of services/income trust wide(c12m) and minimise the financial impact. • Executive oversight of recruitment through vacancy control panel to enact changes including vacancy freezes where required.	The creation of a Transformation group (identified leads and initial meeting held) 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 BPG/ EDG. Vacancy control panel to review progress and amend recruitment controls monthly. Vacancy control panel to oversee the development of other mitigations including over-establishment mindful of turnover.	28/02/2017 31/03/2017 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
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. •	Discussed at Joint Executive Board on 9th Jan 2017 (JEB currently holding the risk), further review planned at next JEB on 13th February 2017. Authorising additional staff overtime.	13/02/2017 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.	Create 3 reduced ligature-point bedrooms per acute ward including the fitting of sensor taps, anti-ligature ceilings, anti-ligature windows and fixed beds. Ensure effective implementation of new observation policy. As part of the service redesign ensuring that all environments meet the agreed the specification for reduced fixed ligature points.	28/02/2017 31/03/2017 28/09/2017

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.	31/03/2017
							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.	28/02/2017
							Revised approach to training and training compliance to be developed and agreed for Bank staff.	15/03/2017
							Review of content of induction training.	28/02/2017
							Further discussions with CCG on timescales for repeat training and new starters.	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