Sheffield Health and Social Care NHS
NHS Foundation Trust

OPEN BOARD OF DIRECTORS
8th February 2017

Item 6

TITLE OF PAPER	**Board Assurance Framework (BAF)**
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance
ACTION REQUIRED	Discussion by the Board.

OUTCOME	To have an agreed BAF in place that is regularly maintained, monitored and reviewed.
TIMETABLE FOR DECISION	The current iteration of the BAF had been presented to the Audit Committee on 31st January 2017 for approval.
LINKS TO OTHER KEY REPORTS / DECISIONS	• Internal Auditor reports covering BAF and Risk Management Arrangements • Risk Management Strategy
LINKS TO OTHER RELEVANT FRAMEWORKS, BAF, RISK, OUTCOMES ETC	BAF links to strategic objectives, corporate risk register, directorate risk registers, NHS Improvement's regulatory framework and Provider Licence and Annual Governance Statement
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Implications of individual risks are highlighted on 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 standing orders if a BAF is not in situ and reviewed regularly. Breach of NHS Improvement's governance regulations and provider licence if not in situ.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	January 2017

Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

OPEN BOARD OF DIRECTORS

Report to: **Board of Directors**

Date: **8th February 2017**

Subject: **Board Assurance Framework (BAF) 2016/17**

Presented by: **Margaret Saunders, Director of Corporate Governance**

Report Author: **Sam Stoddart, Deputy Board Secretary**

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1. Purpose

The BAF for the financial year 2016/2017 was presented to Audit Committee on 31st January and agreed it could be presented to the Board of Directors for approval in February 2017.

2. Summary

"An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect."
The HM Treasury Guidance on Assurance Frameworks (2012)

The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives in order to provide the Board with real confidence that they are providing thorough oversight of strategic risk. It is a tool to capture, report and monitor key risks to strategic objectives, as well as identifying and implementing corrective actions. In addition, it provides assurance that the Trust is able to deliver its objectives and supports the management of potential risks and actual risks. It enables the Board to assess the **controls** in place to mitigate risks and review the **assurances** to check the controls are working.

Discharging a Board's responsibility and retaining oversight should naturally lead board members to regularly test and challenge their current understanding of the internal and external environment within which they operate and ensure that they have effective horizon scanning and risk capture processes in place to provide confidence that the Board is fully sighted on its key strategic risks.

The attached BAF for 2016/17 has been mapped to the Trust's strategic objectives. Individual risks have been assigned to the Board of Directors or Board Committee, as shown within this report.

The risks on the Board Assurance Framework have been graded using the 5 x 5 risk matrix below.

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

Following presentation in October 2016 all risks have been reviewed during December and January. For ease of reference each line has been numbered. Please note that not all risks require updating, but below is a matrix which shows where revisions have taken place.

Key ✓ = change made
x = no change made
⇩ = reduction if RAG rating to green

Risk No.	Line No.	Subject	Controls Updated	Gaps in control updated	Internal assurance updated	External Assurance Updated	Gaps in Assurance updated	Rating of Gaps changed	Actions updated	Target Date updated
1.1	1	CQC action plan	✓	x	✓	✓	✓	x	✓	✓
1.1	2	Director of Care Standards	✓	x	✓	x	✓	x	✓	✓
1.1	3	User engagement	✓	✓	x	x	x	x	✓	✓
1.1	4	Staff survey	✓	x	✓	x	x	x	✓	✓
1.1	5	Training	✓	✓	x	x	✓	x	✓	x
1.1	6	Nurse revalidation	x	✓	✓	✓		x	✓	
1.1	7	Collaborative. Care Planning	x	x	✓	✓	x	✓⇩	✓	✓
1.1	8	Acute & Scheduled . Care Pathways	x	x	x	x	x	x	✓	✓
1.1	9	Policies	✓	x	✓	x	x	x	✓	✓
1.1	10	QI & A strategy	x	x	x	x	x	x	x	x
1.1	11	Audit	x	✓	x	x	x	x	x	x
1.1	12	Staffing	x	✓	✓	x	x	x	x	x
1.1	13	Sickness	✓	x	✓	x	✓	✓⇩	✓	✓
1.1	14	Committee& group governance	✓	x	x	x	x	x	✓	✓
1.1	15	Gate keeping	x	x	x	x	x	x	x	x
1.2	16	Physical health	x	✓	✓	x	✓	x	✓	✓
1.3	17	Incident Management	x	x	x	x	x	x	x	x
1.3	18	Complaints	x	x	x	x	x	x	x	x
1.3	19	Mortality review	✓	x	x	x	✓	x	✓	✓
1.4	20	Registration requirements	✓	✓	✓	✓	✓	x	✓	✓
1.4	21	Staff training MCA/MHA	✓	✓	✓	✓	✓	x	✓	✓
2.1	22	SU Engagement strategy	x	x	x	x	x	x	✓	✓

Risk No.	Line No.	Subject	Controls Updated	Gaps in control updated	Internal assurance updated	External Assurance Updated	Gaps in Assurance updated	Rating of Gaps changed	Actions updated	Target Date updated
3.1	23	Gate keeping	x	✓	x	x	✓	✓ ⇩	✓	✓
3.2		MCA/MHA	Removed – duplication (risk 1.4 line 20/21)							
3.3	24	Collaborative working	x	x	x	x	x	x	x	x
4.1	25	Plans/ strategies & fin. Plans	x	x	x	x	x	x	x	x
4.1	26	Fin policies & procedures.	x	x	x	x	x	x	x	x
4.1	27	Internal control	x	x	x	x	x	x	x	x
4.1	28	CIP & Disinvestment. plan shortfall mitigation	x	x	x	x	x	x	x	x
4.1	29	Contracting arrangements	x	x	x	x	x	x	x	✓
4.2		MH Clustering	Removed Aug 2016							
4.3	30	Board committees/ compliance	x	x	x	x	x	x	x	✓
4.3		Clinical Governance structures	Removed – addressed in risk 1.1 (8, 14), 1.4 (20), 4.1 (28)							
4.3		Compliance with CQC	Removed – duplication of other CQC compliance/standards risks							
4.4	31	Compliance Provider licence	x	x	x	x	x	x	x	✓
4.4	32	Compliance SOF	x	x	x	x	x	x	x	x
5.1	33	Staff FFT	x	x	x	x	x	x	✓	✓
5.1		KPIs	Removed – addressed in risk 5.1 line 35							
5.1	34	Staff survey	x	x	✓	x	x	x	x	✓
5.1	35	Leadership Development Strategy	x	x	✓	x	x	x	✓	✓
5.2	36	Policies	x	x	x	x	✓	x	x	x
5.2	37	WWB	x	x	x	x	x	x	x	x
5.2	38	Workforce Strategy	x	x	✓	x	x	x	x	x
5.3	39	Mandatory training	x	✓	x	x	x	x	x	x
5.3	40	Training compliance	✓	x	x	✓	✓	x	x	x
5.3		Training course evaluation	Removed – address in risk 5.3 line 40							

3. Required Actions

The Board is asked to:

- Receive and approve the BAF;

4. Next Steps

Following on from a Board Development Session in October 2016, a further development session will take place before year end to

(a) Identify the risks associated with the new Trust Strategic Objectives;
(b) Agree a revised format for the BAF in line with the outcomes of the development session to take effective in the new financial year;
(c) Populate the new BAF with the newly identified risks for presentation to the April 2017 Audit Committee.

5. Monitoring Arrangements

The Executive Directors Group, Audit Committee and Board will continue to receive the BAF on a quarterly basis.

The Director of Corporate Governance will ensure that the BAF is regularly updated by executive leads.

6. Contact Details

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Deputy Board Secretary
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Email: Samantha.stoddart@shsc.nhs.uk

Board Assurance Framework 2016-17

Risk Rating Matrix

The attached Board Assurance Framework (BAF) has been scored using the risk rating matrix shown below.

	Likelihood				
Consequence ↓	Rare	Unlikely	Possible	Likely	Almost certain
	1	2	3	4	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**

Green indicates a very low level risk

Yellow indicates a low level risk

Orange indicates a moderate level risk

Red indicates a high level risk

Key to Risk Leads:

CC	Clive Clarke
MH	Mike Hunter
LL	Liz Lightbown
PE	Phillip Easthope
KT	Kevan Taylor
DW	Dean Wilson

Key to Risk Grading:

C	=	Consequence
L	=	Likelihood
R	=	Rating (consequence x likelihood)

Board Assurance Framework 2016-17

Acronym Key

Because of limited space, acronyms are used throughout the BAF. Below is a key to those used.

AC	Audit Committee
ACR	Acute Care Reconfiguration
BoD	Board of Directors
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CQUIN	Commissioning for Quality & Innovation
DoLs	Deprivation of Liberty
EDG	Executive Director's Group
FIC	Finance and Investment Committee
MHA	Mental Health Act
NHS I	NHS Improvement
QAC	Quality Assurance Committee
SUEMU	Service User Monitoring Unit
SUSEG	Service User Engagement Group
WODC	Workforce & Organisation Development Committee

Strategic Objectives 2016/17

Strategic Objective 1

To continually improve the quality and efficiency of our services in terms of safety, outcomes and service user experience

1.1 That all services, both clinical and corporate, will produce and deliver an annual quality improvement programme
1.2 The Trust becomes fully compliant with the CQC's recommendations
1.3 The Trust will review the safety of its services through the establishment of a peer review group
1.4 That each service will define service standards, based on CQC domains of care and those locally determined, and publish these in service areas in order to strengthen local
1.5 We will meet national minimum waiting times for access to evidence based treatment and where we can, further reduce waiting times
1.6 That the Trust's principal approach to quality improvement, Microsystems, is embedded within clinical and corporate teams
1.7 Ensure we are providing appropriate physical health care to meet service user needs
1.8 We will develop therapeutic teams that deliver NICE guidance approved treatments with a skill mix which recognises the needs of our service users

Strategic Objective 2

Involving Service Users In Designing and Delivering Care and Support

2.1 All services will seek feedback from service users, their families and carers and use this to inform their quality improvement plans
2.2 Continue to develop the Service User Experience and Monitoring Unit (SUEMU) to collect information on patient experience and refresh the strategy for service user involvement
2.3 That the Trust will explore involving service users in the delivery of services eg. peer support and management of service pathways

Strategic Objective 3

Transforming the Services We Deliver

3.1 We will provide effective alternatives to hospital admission and better approaches to rehabilitation in order to further reduce admissions, lengths of stay and to cease out of town placements
3.2 All care pathways are improved to offer access to evidence based treatments
3.3 Opportunities to deliver new services are explored, where possible
3.4 Where appropriate, all teams will implement collaborative care planning by the end of 2016- 17
3.5 We will continue our work to reduce all forms of chemical, physical and mechanical restraint
3.6 Urgent care pathways are enhanced, offering 24/7 access to high quality care, across the entire age range
3.7 Work in partnership with Seven Hills Care and Support Ltd in line with the first year of the company's agreed two year business plan.

Strategic Objective 4

Maintaining Our Financial Sustainability

4.1 That all services review their productivity and ensure appropriate action is undertaken to increase it
4.2 That all services have an agreed plan to reduce costs over the next three year period
4.3 That plans are implemented to reduce the Trust's estate

Strategic Objective 5

Workforce Engagement

5.1 That all services involve their staff in the design and delivery of services

Links between Board Assurance Framework, Corporate Risk Register and Board Committees

BAF Risk No.		Corporate Risk Register Risk No.(s)	Board Committee(s)
1.1	Risk that the quality of care provided falls below expectations and/or standards.	2310, 2948, 3322, 3439, 3591	QAC, WODC
1.2	Risk that service users' physical health needs are not being met effectively.		QAC
1.3	Risk that incidents and complaints reoccur/potential for litigation and/or Coronial or Ombudsman Rulings as a result of ineffective learning/inadequate processes.	3333	QAC
1.4	Risk that Trust may not be fully compliant with CQC registration and regulation requirements, including compliance with the Mental Health Act and Mental Capacity Act.		QAC
2.1	Risk that the Trust will not effectively gather and utilise service user feedback to inform quality improvement.	2125	BoD
3.1	Risk that service users will have to wait longer than expected to receive services (ACR & Rehab).	3611	QAC
3.2	REMOVED		
3.3	Risk that the Trust will not work collaboratively and in partnership with others to achieve its objectives.	2196, 3611	FIC
4.1	Risk that the Trust will not continue to be financially viable and that strategic plans will not deliver the required financial savings.	2161, 2175, 2375, 3591,3616	FIC
4.3	Risk that Trust governance systems may not be sufficiently robust.	2231, 2948, 3327, 3616	BoD
4.4	Risk that terms of Provider Licence may be breached.		BoD
5.1	Potential risk of poor leadership across Trust which inhibits meaningful staff engagement.		WODC
5.2	Risk of staff wellbeing not as positive as it should be.	2206, 2310, 2938	WODC
5.3	Potentially insufficient capacity to deliver all mandatory training across Trust and to improve attendance and monitoring of mandatory training.	2163	WODC

Key:

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

SHSC Board Assurance Framework 2016/17

Risk Ref. No.	Risk Description	Lead	Current Risk Score			Target Risk Score			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in control and assurances	Actions Assigned to	Target Date	Line No
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Strategic Objective 1: To continually improve the quality and efficiency of our services in terms of safety, outcomes and service user experience																				
Risk No. 1.1	Risk that the quality of care provided falls below expectations and/or standards.	MH	4	3	12	3	2	6	Action Plan Tracker to address gaps in compliance identified from 2014 inspection updated and all actions closed down prior to November 2016 inspection. A new design of action plan developed and in place to ensure clear signposting to CQC inspection reports and for easy use and understanding by services. A tracker control spread sheet also developed and in use to monitor action plan responses to CQC by deadlines and progress to closure of action plans (this document is used by the Care Quality team only)	No gaps in control	Closure of action plan tracker managed through Quality Assurance Summit held on 31/10/16 and reported closure of actions with assurance through EDG and QAC New action plans and reporting through EDG and QAC monthly. A programme of "Mock Inspections" completed to high risk services prior to Trust CQC Inspection Nov 16. This programme to continue post inspection with support and formal reports and action plans to address gaps. This process will be embedded into everyday practice. Mock inspections will be unannounced with reporting through EDG and QAC	YTD	CQC inspections with verbal feedback and formal reports with action plans (Well Led; unannounced MHA Monitoring inspections; unannounced ASC inspections; full Trust inspection Nov 2016).	June 15 (Provider) Aug 16 (Well-led)	Tangible evidence of completed actions.		A Quality Assurance process to be built into the action plan process and evidence to be collected/audited to provide assurance of completion of actions and embedding.	LL	Mar-17	**1**
									Interim part time post of Director of Care Standards and Care Standards Manager in place from June 2016. Interim full time Care Standards Coordinator in place from Nov 2016 plus Interim Support from a Community Psychotherapist 1 day a week from Nov 16.	Appointment to the substantive new post of Director of Care Standards & Quality Assurance.	Interim Director and Manager posts secured contracts until June 2017. Interim Coordinator contract in place until 31 March 2017. Interim Psychotherapist support secured to November 2017.	YTD	None required	Dec-16	Failed to appoint to Substantive post of Director of Care Standards		Interim appointments extended to June 2017. Director of Care Standards substantive post to be re-advertised	LL	Jun-17	**2**
									Implementation of Service User Engagement Strategy ratified by Board in July 2016. System being developed to map feedback from Service Users as sources of assurance against relevant care standards. Register being developed with Head of Service User Engagement Monitoring Unit (SUEMU) capture and mapping of good work ongoing. Quality Improvement and Assurance Strategy implementation plan and quality assurance framework inlcudes information about and learning from service user experience. Appointment of Band 6 Engagement Officer (effective Jan 17).	Service User Engagement Stategy not fully implemented. Service User Experience Monitoring Unit not yet fully established to provide robust mechanism for capturing experience intelligence. Long-term sickness of key staff.	Service user experience surveys undertaken, eg Friends and Family Test, exit surveys, capture quality of care provision, results monitored through Service User Engagement Group (SUSEG). Comprehensive Service User Experience Report (SUSEG and Quality Assurance Committee [QAC]) Eliminating Mixed Sex Accommodation report (QAC)	YTD biannual June 16	CQC inspections NHS England FFT (Service user) Internal audit reports	Jun 15 (Provider) Aug 16 (Well-led) Monthly to date June 16	Improvements to be made to assurance framework to map service user feedback and involvement to care standards and reporting through Trust governance structure		Service user experience to be better utilised to improve services and to provide assurance of compliance through completion of assurance framework mapping exercise and service user Involvement Register Band 7 being recruited to work with SU Engagement Group and Quality Improvement Team. Service User Experience Monitoring Unit to be fully established.	MH MH MH	Mar 17 Mar 17 Mar 17	**3**
									Staff survey in place to provide feedback to Trust to provide assurance against relevant care standards. Action plan in place and being implemented following publication of 2015 staff survey results which showed increase in demotivated staff and increase in staff experiencing violence.	Lack of staff feedback mechanisms to provide assurance against specific and relevant KLOE against Care Standards	Workforce Report/Staff Survey Report (WODC). Analysis undertaken of areas identified as poor and reported to EDG and WODC on outcomes.	Feb 16 Sept 16	NHS England benchmarking (Staff survey) NHS England benchmarking FFT (staff)	Feb 16 May 16	Lack of an assurance framework to map staff feedback to care standards and reporting through Trust governance structure		Staff feedback to be better utilised to improve services and to provide assurance of compliance through completion of assurance framework mapping exercise	LL	Mar 17	**4**

SHSC Board Assurance Framework 2016/17

Risk Ref. No.	Risk Description	Lead	Current Risk Score			Target Risk Score			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in control and assurances	Actions Assigned to	Target Date	Line No
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 1.1 cont'd	Risk that the quality of care provided falls below expectations and/or standards.	MH	4	3	12	3	2	6	Training Needs Analysis (TNA) undertaken and Mandatory training programme in place to ensure staff have appropriate skills Staff supervised and appraised in accordance with revised policy. Mandatory Training Steering Group in place. Plans in place and increases in Mandatory Training now resulting in majority of all 20 Mandatory Training subject area targets being met (as at June 2016). An Annual Training Plan has been developed which plans the release of staff to attend training to meet compliance standards for each year going forward. A plan to achieve the required levels of Mandatory Training (agreed with CCG Sept 16) is now in place with regular reports to EDG, WODC and Board as well as CCG with agreed trajectories in place and being achieved in almost all subjects.	Training uptake has been below target Trust set of 90% (previously 85%) for some subjects including high risk areas of practice. Supervision rates inconsistent.	Mandatory training compliance reports (reported to WODC and BoD) with clear information about compliance rates in all 20 MT subjects. Action plan in place with monthly (previously weekly) reports to EDG. Workforce reports to WODC (previously BoD). Nurse Revalidation Steering Group reporting to EDG, BoD, WODC. HeArt system purchased and implemented. Directorate Service Reviews. Microsystem Project initiated - will report to WODC/EDG	YTD YTD Monthly ¼ly Nov 16	CQC inspection reports. NHS I reporting. Linking with and reporting to CCG with regard to increased compliance plans	June 15 (Provider) Aug 16 (Well-led) ¼ly monthly			Directorates are prioritising release of staff whose training has expired or due to expire.	DW	Mar-17	**5**
									National Nurse Revalidation system introduced		Deputy Chief Nurse reports to EDG on revalidation progress on a six monthly basis. HeArt system purchased and implemented and operational until 2018.	Oct-16			No known gaps			LL		**6**
									Collaborative care planning (CCP) is operational across the Trust. Collaborative Care Planning Group reinstated and its Terms of Reference revised and refreshed.	Not fully rolled out in all service areas and no agreed audit process in place.	CCP Group reports to Clinical Effectiveness Group. Clinical Effectiveness Group reports to QAC.	YTD ¼ly	Verbal feedback from CQC on effectiveness of CCP (as part of Nov 16 Inspection)	Dec-16			Work underway to roll out CCP across all teams as part of remit of CCP Group.	MH	Mar-17	**7**
									Acute and Scheduled Care Pathways (ACP and SCP) (include safety, quality and performance standards) fully implemented	Limited assurance that effective clinical governance systems across all clinical teams is in place.	Directorate performance reviews	¼ly					Implementation of Quality Improvement & Assurance Strategy. Internal Audit commissioned for Q4.	MH MH	Mar 17 Mar 17	**8**
									Policies provide framework/ parameters for staff to operate within. Policy on Policies revised and in place. Interim Policy Coordinator appointed who addressed immediate out of date documents.	Number of policies past their review dates (target date 30/9/16). Number of policies do not reflect current legislation (target date 30/9/16).	Policy log to review and refresh policy documents. Monthly (previously weekly) progress reported on outstanding policies to EDG.	¼ly monthly			Policy process including approval and ratification is not audited.		All out of date policies to be updated and approved to include legislation changes (majority completed as at Jan 17). Policy Governance Group relaunched with revised ToR. Audit of policy process agreed with 360 Assurance to include policy approval and ratification (Q4).	KT KT KT	Mar 17 Feb 17 Apr 17	**9**

SHSC Board Assurance Framework 2016/17

Risk Ref. No.	Risk Description	Lead	Current Risk Score			Target Risk Score			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in control and assurances	Actions Assigned to	Target Date	Line No
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 1.1 cont'd	Risk that the quality of care provided falls below expectations and/or standards.	MH	4	3	12	3	2	6	Quality Improvement and Assurance Strategy developed and approved. Robust strategy implementation plan with outcomes in place and to be monitored through QAC		QIAS implementation plan report to QAC	biannual						MH		10
									Audit programme in operation identifies any shortfalls in practice. Clinical Effectiveness Group established. Clinical Audit Manager appointed.		Clinical audit reports (EDG and QAC) Group to report to QAC and EDG	May 16 ¼ly	Quarterly oversight by CCG	¼ly				MH		11
									Staffing establishments agreed and monitored. Purchasing e-rostering system Using Meridian productivity tools when redesigning staffing models.	Partial Implementation of the Staffing Capacity & Capability electronic management & reporting system (Allocate)	Staffing capacity & capability for Inpatuient wards is managed at Ward and Service Line Level, by the Ward Managers, Senior Nurse/Directorate Assistant Clinical Directors and overseen by the Deputy Chief Nurse in a monthly operational group. Wards monitor their staffing daily and Staffing Capacity & Capability is reported to Board monthly. 3 systems are merging (e-rostering, SafeCare and Allocate) to become the Safer Staffing Group which will have new Terms of Reference, meet monthly and report to EDG monthly.	YTD YTD	Internal Audit Report (EDG & BoD) (staffing capacity)	Jun-16	Manual redeployment of staff in response to changes in acuity, dependancy and clinical demand cannot be captured in realtime and reported in the Ward & Board reports yet. All reports are retrospective and we do not have the flexibility yet to alter planned staffing levels in the reports to reflect staff changes to better manage patient demand and staffing capacity.		Full implementation of the Allocate e-rostering system and the Safe Care Module for acuity & dependency.	LL	Mar-17	12
									Sickness absence rates monitored (now moved into lower quartile). Stress management policy in place Sickness Absence Case Manager appointed (Aug 16 for 1 yr)		Workforce Performance Report (WODC and BoD) including numbers of staff who are at each stage in the policy. Periodic report to WODC and BoD to report of progress following appointment of case manager.	YTD Feb 17	Staff Survey Regional benchmarking data	Feb 16 Monthly				DW		13
									Committees and groups established that monitor quality of care provision: 1. Board Committees - Quality Assurance Committee/WODC. 2. Sub-committee structures including Infection Control, Safeguarding, Service User Safety, Health and Safety. To address limited assurance provided by Internal Audit re Serious Case reviews the following is now in place: 1. Safeguarding Adult & Incident Management policies updated in relation to external reviews to strengthen governance responsibilities. 2. All actions completed in relation to the internal audit of safeguarding adult serious case reviews and a central record of all evidence is now in place.		• Revised ToR for all Board Committees Minutes of meetings and schedules of attendance • QAC/WODC reports to Board • Infection Control Quarterly Report • Incident Management Quarterly Report • Workforce Quarterly Report • Progress updates from Service User Safety Group and Service User Engagement Group • Self Harm Report • Missing Persons Report • Safeguarding adults quarterly report • Safeguarding children quarterly report	Sept 16 YTD YTD ¼ly ¼ly ¼ly ¼ly ¼ly	Internal Audit Report on Governance Structures NHS Improvement Reviews Internal Audit Report on Serious Case Reviews (Adult Safeguarding) Care Quality Commission (CQC) Inspections	Dec 15 Apr 16 July 16 Jun 15 (Provider) Aug 16 (Well-led)	Limited Assurance provided		Actions from audit report on governance structures to be reviewed and addressed. Safeguarding Adult Steering Group ToR and standard agenda have been reviewed - awaiting ratification (QAC).	KT LL	Mar 17 Feb 17	14

SHSC Board Assurance Framework 2016/17

Risk Ref. No.	Risk Description	Lead	Current Risk Score			Target Risk Score			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in control and assurances	Actions Assigned to	Target Date	Line No
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 1.1 cont'd	Risk that the quality of care provided falls below expectations and/or standards.	MH	4	3	12	3	2	6	Effective gate-keeping mechanisms in place for in-patient wards and reduction of bed numbers programme operational	No known gaps	Service User Experience Report (SUSEG and QAC) ¼ly Acute care reconfiguration progress reports (EDG/BoD) (monthly) Rehab programme update (EDG/BoD) (monthly) Weekly Bed Management Meetings CMHT Community Meetings	¼ly YTD Sep 16	HealthWatch inspections Clinical Commissioning Group (CCG) contract monitoring	 Monthly	No known gaps			CC	No further action - risk to be monitored	**15**
Risk No. 1.2	Risk that service users' physical health needs are not being met effectively	LL	4	3	12	3	2	6	Physical Health Strategy implementation monitored by Physical Health Implementation Group	Physical Health Implementation Group not currently running. No overarching strategy and implementation plan for physical health.	Nutrition Group reports and minutes reporting to Service User Safety Group (monthly) and EDG (monthly) and QAC (six-monthly).	YTD	CQUIN with NHS Sheffield CCG	Oct 14 (last audit)	Gaps in monitoring physical health. Checks not being undertaken. Lack of reporting on physical health. Lack of governance structure for oversight of physical health.		Physical health monitoring to be strengthened. Task & Finish Group to deliver outstanding actions. New Terms of Reference for Physical Health Implementation Group required plus aligning of existing work streams.	LL LL	Mar 17 Feb 17	**16**
Risk No. 1.3	Risk that incidents and complaints reoccur/ potential for litigation and/or Coronial or Ombudsman Rulings as a result of ineffective learning/inadequate processes.	MH	4	3	12	4	2	8	Incident management processes are in place.	No known gaps	Incident management reports (EDG/SUSG/QAC) Savile Report updates (EDG/BoD)	Jun 16 Jul 16	Sheffield CCG oversees incident management processes.		No known gaps			MH		**17**
									Complaints processes are in place. Revised complaints policy approved Oct 16.	No known gaps	Complaints Report (EDG/SUSG/QAC/HeathWatch) Complaints Annual Report (EDG/BoD) Report on review of complaints processes (EDG/SUSG/QAC)	¼ly Annual June 16	Sheffield CCG/Ombudsman oversees complaint management processes for referred complaints.		No known gaps			MH		**18**
									Mortality Review Group established to monitor all deaths. Trust has joined the Northern Alliance of Trusts (benchmarking).		Review of deaths undertaken for 2015/16 (EDG/QAC) . Group report to EDG/QAC	Feb 16 ¼ly	NHS England Benchmarking exercise Collaborative working with group of Trusts, following Mazars review.	Feb-16				MH		**19**

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			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 1.4	Risk that Trust may not be fully compliant with CQC registration and regulation requirements, including compliance with the Mental Health Act and Mental Capacity Act	LL	4	3	12	3	2	6	Registration requirements managed by Head of Clinical Governance. New Head of Mental Health Legislation in post from 16/01/17. Mock inspection system established to include MHA/MCA/DoLS testing. CQC MHA Monitoring Inspection reports and action plans managed and coordinated through Care Quality Standards team from December 2016. Close working between Care Quality team, Head of MH Legislation and MHA and MCA Committee Chairs.	No known gaps in control for registration requirements. MHA Code of Practice not fully implemented/ understood. No formal report and action plans from weekly MHA Audits.	Relevant policies updated, approved and in use from October 2016 re MHA Code of Practice. MHA Committee, MCA Steering Group reporting to EDG and QAC. Weekly MHA Compliance Audits of inpatient areas take place. Results are shared with all teams and reported to the MHA Committee monthly and EDG quartely. CQC Inspection reports and formal action plans including results from mock inspections reported to EDG/QAC monthly.	YTD	CQC inspection report Well Led Aug 2016 Regulation Breach for MHA Code of Practice not fully implemented Internal Audit reports National Mental Health Benchmarking data	Jun 15 (Provider) Well-led (May 16) CQC MHA Monitoring reports and action plans timely as required	Reports identify areas for improvement and a breach in regulations. Evidence required for completed actions.		Joint working between Care Quality Team, new Head of Mental Health Legislation and Chairs of MHA and MCA Committees, including MHA/Medical Records Manager from December 2016 with formal reporting to EDG and QAC from January 2017. Formal reporting and action plans from weekly MHA audits to be developed. QA Framework for evidence of completed actions for assurance to be developed as part of work for risk 1.1 above.	LL	Mar-17	**20**
									Staff training compliance for MHA, MCA and DoLS monitored and reported monthly	MCA Level 1 compliance target is currently at 56.21% (729) which includes those staff whose compliance expired within the last 6 months. MCA Level 2 compliance target is currently at 52.49% (559) which includes those staff whose compliance expired within the last 6 months. DoLS Level 1 training compliance target is currently at 90.81% (1967) which includes those staff whose compliance expired within the last 6 months. DoLS Level 2 training compliance target is currently at 70.59% (72) which includes those staff whose compliance expired within the last 6 months	Training statistics and short and long term trajectory targets reported monthly to EDG and QAC MHA and MCA/DoLs Committees report to EDG & QAC quarterly The MCA audit group meets monthly	YTD ¼ly	Internal audit reports on MCA/DoLs. CQC Well Led inspection report Aug 2016 regulation breach for low staff training levels	Jul 15/Mar 16 May 16	Internal audit highlighted number of gaps - limited assurance given. CQC Well Led inspection shows breach in regulations.		MCA A programme of Workbook Sessions continues across the trust. MCA Level 1 training will from 1 April 2016 be included in Mandatory Training Days. A programme of MCA Level 2 learning with back up rota is in place for 2017/18. In January 2017 introduction of the DoLS eLearning module to ensure on-going compliance target is maintained. Additional DoLS training sessions in situ during January to March 2017 to achieve Trust compliance target of 90%. Revised forms have been cascaded across teams and uploaded onto the Intranet and Insight.	LL	Mar-17	**21**
Strategic Objective 2: Involving Service Users In Designing and Delivering Care and Support																				
Risk No. 2.1	Risk that the Trust will not effectively gather and utilise service user feedback to inform quality improvement.	KT	3	3	9	3	1	3	Service User Engagement Strategy refreshed for 2016-20		Refreshed strategy presented to and approved by BoD Progress is monitored by SUSEG Service user engagement reports (SUSEG/QAC)	June 16 ¼ly May 16			Strategy implementation plan not yet in place		Detailed Implementation plan to be developed and approved by EDG. Following EDG approval, implementation plan to be taken to Board.	MH	Jan 17 Feb 17	**22**
Strategic Objective 3: Transforming the Services We Deliver																				

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Risk No. 3.1	Risk that service users will have to wait longer than expected to receive services (ACR and Rehab).	CC	2	4	8	3	2	6	Effective gate-keeping mechanisms in place, including liaison with primary care services.		Performance reports (EDG/BoD) Quality Improvement & Assurance Stratetgy Directorate Service Reviews (EDG) Transformation/reconfiguration progress reports (EDG/BoD) Microsystem approach	YTD	National Benchmarking of Mental Health and Learning Disabilities NHS Improvement Ratings	Apr 16 (for 14/15) Apr 16				CC		**23**
Risk No. 3.3	Risk that the Trust will not work collaboratively and in partnership with others to achieve its objectives.	KT	3	3	9	3	1	3	Board to Board mechanisms established with Local Authority, Sheffield Teaching Hospitals and NHS Sheffield Clinical Commissioning Group. Sheffield Transformation Board. South Yorkshire & Bassetlaw STP. New appointments for Director of Strategic Planning and Clinical Director for Strategic Partnerships.	No known gaps	Chief Executive Updates to Board of Directors CEO Member and Director of Partnership Working Group	YTD			No known gaps			KT		**24**

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			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Strategic Objective 4: Maintaining Our Financial Sustainability																				
Risk No.4.1	Risk that the Trust will not continue to be financially viable and that strategic plans will not deliver the required financial savings.	PE	5	2	10	4	1	4	Clear plans and strategies in place to inform trust direction: Robust financial planning mechanisms, including any loss of contract or reduction in contract value over £50,000 treated as a divestment of service	No known gaps	Finance report to BoD AC going concern assessment FIC papers and minutes	YTD April 16 YTD	Performance against plan monitored externally by NHS Improvement. Trust current Continuity of Services risk rating is 4. Internal audit report	Monthly 1/4ly Dec 16	No known gaps			PE		**25**
									The Trust has robust financial policies and procedures including pricing, budget setting, internal controls. The Finance and Investment Committee maintains an overview of the trust's financial processes, ensuring finances are managed within allocated resources to deliver an efficient and effective service.	No known gaps	FIC papers and minutes EDG & FIC ratification of policies	YTD	Internal Audit - financial management and business development audit reports		No known gaps			PE		**26**
									The Audit Committee has specific responsibility for ensuring effective evidence exists of internal control.	No known gaps	AC papers and minutes	¼ly	Internal & External Audit Work programme and head of internal audit opinion	Dec-16	No known gaps			PE		**27**
									CIP & Divestment Plans shortfalls mitigated against in financial planning through reserves. Performance against CIP & Disinvestment plans monitored through EDG and reported to FIC & Board. Performance monitoring escalation in place. The Director of Finance and Director of Operations meet with significantly overspending (YTD or Forecast) directorates Monthly.	Financial governance not embedded down to ward level	EDG reports and minutes FIC reports and minutes Board reports and minutes Financial performance reviews Quality Improvement and Assurance Strategy in place (QAC/BoD)	YTD 6-montly			No known gaps		Action plan being developed to address gaps to be implemented in new financial year (17/18)	PE	Mar 17	**28**
									Contracting arrangements are in place with commissioners	Notice given on number of local authority commissioned services within Learning Disabilities. Local Authority Section 75 contract negotiations ongoing	FIC oversight of contractual framework	YTD	Exec to Exec meetings with Local Authority Monthly meetings being held with LA Regular meetings with NHSE Contract Monitoring Group meeting papers and minutes	1/4ly Weekly Monthly	Uncertainty around term of LD contracts. Impact on risk quantification and management		Contract negotiations ongoing with Local Authority	PE	Mar 17	**29**
Risk No. 4.3	Risk that Trust governance systems may not be sufficiently robust	KT	4	3	12	4	1	4	Board committees established and operational. Compliance with NHS Constitution, NHS Improvement's Single Oversight Framework and Code of Governance monitored.		All Board Committee Terms of Reference have been reviewed and revised. . Annual Governance Statement. . Quality Governance self-assessment. . Audit Committee self-assessments, including going concern.	May-16 May 16 May 16 May 16	Internal Audit report on response to Francis subsumed by Committee Governance Internal Audit report.	Apr-16	Reports identify areas for improvement.		Actions from Internal Audit report to be implemented External 'Well-led framework for governance reviews' to be undertaken.	PE KT	Mar 17 May 17	**30**
Risk No. 4.4	Risk that terms of Provider Licence may be breached	KT	4	2	8	3	1	3	Compliance with Terms of Provider Licence is monitored	Uncertainty around responsibilities in respect of Licence	Appointment of Director of Corporate Governance	Sep-16	NHS I performance telephone reviews undertaken Continuity of Services and governance rating	1/4ly 1/4ly	Lack of internal assurance due to insufficient monitoring of provider licence		Internal audit being undertaken.	KT	Mar-17	**31**

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			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 4.4 cont'd	Risk that terms of Provider Licence may be breached	KT	4	2	8	3	1	3	Compliance with Single Oversight Framework is monitored	No known gaps			NHS Improvement performance telephone reviews undertaken Continuity of Services and governance rating	1/4ly 1/4ly	No known gaps			KT		32
Strategic Objective 5: Workforce Engagement																				
Risk No. 5.1	Potential risk of poor leadership across Trust which inhibits meaningful staff engagement.	DW	3	3	9	2	2	4	Staff Friends and Family Test records staff feedback (recommend trust as place to work)	No known gaps	Service User Experience Report	May-16	NHS England benchmarking (Staff survey) Staff FFT benchmarking results	Feb 16 May 16	Feedback not used effectively to make improvements		Staff FFT results to be better utilised to improve services. Cross-check to Staff Survey to be presented to EDG in Q4 2016/17 along with action plan if necessary.	DW DW	Mar 17 Mar 17	33
									Annual staff survey gauges staff engagement	No known gaps	Workforce Report/Staff Survey Report (WODC) including report on performance against identified KPIs Analysis undertaken of areas identified as poor and report to EDG on outcome	YTD Sept 16	NHS England benchmarking (Staff survey) NHS England benchmarking FFT (staff)	Feb 16 May 16	Low scores in staff motivation and staff experiencing violence		Action plan in place following publication of 2015 staff survey results. Actions to be implemented. Indepth analysis to identify area(s) of the Trust reporting high levels, identified to one specific incident. This will be reviewed following 2016 Staff Survey.	DW	Mar 17	34
									Leadership Development Strategy	Strategy not yet established but being progressed by multi-directorate group.							Strategy to be presented to EDG to approval.	DW	Jan-17	35
Risk No. 5.2	Risk of poor staff wellbeing	DW	3	1	3	2	1	2	Suites of policies in place to protect and support staff: • Lone working • stress • supervision • Risk management • Incident management • Relationships at work • Health and safety • Bullying and harassment • Grievance • Disciplinary • Positive management of aggression • Sickness absence • Leave • Organisational change	No known gaps	Reports to HR Policy Groups, Executive Directors Group, Workforce and Organisation Development Committee and the Board of Directors	YTD	NHS Staff Survey NHS England Friends and Family Test benchmarking	Feb-16 May 16	Low scores in staff motivation and staff experiencing violence (2015 result)		Staff FFT results to be better utilised to improve services (reference risk 5.1 above). Numerous staff support mechanisms in place as reported in Workforce Reports etc. No issues in this respect.	DW	Mar-17	36
									Self referral Workplace Wellbeing Service established	No known gaps					No known gaps			DW		37
									Workforce Strategy monitored by WODC	No known gaps	Reviewed and updated annually and reported to WODC.	Yearly			No known gaps			DW		38
Risk No. 5.3	Potentially insufficient capacity to deliver all mandatory training across Trust and to improve attendance and monitoring of Mandatory Training.	DW	3	3	9	3	1	3	Mandatory Training policy in place which identifies training requirements and appropriate no of courses set up to reflect requirements. Training competencies mapped on ESR system and regularly reviewed	Potential sickness absence of trainers impacting on ability to deliver a limited number of courses.	WODC training report EDG report Board report	1/4ly weekly monthly	CCG monitoring NHS I monitoring CQC inspection reports	Monthly Quarterly			Course competencies/modules have been reviewed by the Education and Training Department. Additional training initiated. Gap analysis completed. Additional dates and courses implemented to achieve Trust target of Mandatory Training subjects.	DW	Mar 17	39

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			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd						
Risk No. 5.3 cont'd	Potentially insufficient capacity to deliver all mandatory training across Trust and to improve attendance and monitoring of Mandatory Training.	DW	3	3	9	3	1	3	Training compliance is monitored on a regular basis and reported quarterly on 20 priority training subjects. Separate action plan in place to improve training provision and uptake. Mandatory Training Steering Group established to oversee full improvement implementation plan. Gap analysis completed for capacity of training delivery. Sufficient training courses now offered Trustwide.		WODC training report EDG report Board report	1/4ly weekly monthly	NHS Staff Survey CCG Monitoring	01/02/2016 Monthly	CCG compliance notice still in force pending a number of recurrent months of improvement. Controls now in place to mitigate and CCG closely monitoring (currently satisfied with Trust progress).			DW		**40**