BOARD OF DIRECTORS MEETING (Open)

Date: 12 July 2017 **Item Ref:** 10

TITLE OF PAPER	Board Assurance Framework (BAF) 2017-18
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	Discussion and approval
OUTCOME	To have an agreed BAF in place that is regularly maintained, monitored and reviewed.
TIMETABLE FOR DECISION	The BAF is presented to the Board of Directors (BoD providing the opportunity for verbal feedback to accompany the presentation at the Board of Directors (BoD) on 12 July 2017.
LINKS TO OTHER KEY REPORTS / DECISIONS	Shaping the Future, the Trust Strategy and Strategic Planning Framework 2017 - 2020 Internal Audit Reports covering Board Assurance Framework and Risk Management arrangements.
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	BAF links to strategic objectives, corporate (organisational) 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 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 Standing Orders if BAF not in place and reviewed regularly. Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	Margaret Saunders
Designation	Director of Corporate Governance (Board Secretary)
Date of Report	2 July 2017

SUMMARY REPORT

Report to: Board of Directors

Date: 12 July 2017

Subject: Board Assurance Framework (BAF) 2017-18

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

Author: Margaret Saunders, Director of Corporate Governance (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

All NHS Trusts are required to develop a Board Assurance Framework (BAF). The (BAF) is a key mechanism which Boards use to reinforce strategic focus and improve management of risk. The BAF provides a structure and process which enables the organisation to focus on those risks that may compromise achieving the strategic objectives. It maps out the key controls that should be in place to manage these objectives and records the assurances Committees and the Board of Directors (BoD) has received regarding the effectiveness of the key controls.

The BoD received the Board Assurance Framework 2017/18 – Next Steps paper in June 2017 detailing the process undertaken to populate the SHSC BAF for 2017-18. This was based on the strategic objectives within Shaping the Future, the Trust Strategy and Strategic Planning Framework 2017 - 2020. The Trust is aware delivery of the BAF is a collective responsibility with Executive leads having been identified for the delivery objectives, which form the next level of the strategic planning framework.

The May 2017 workshop focused on identifying the major risks associated with the the four strategic aims of the Trust, Quality and Safety, People, Future Services and Value for Money, and the 16 strategic objectives, with four Delivery Objectives under each Aim, Appendix one. Following the workshop meetings were held with each Executive Lead to populate the 2017/18 BAF. In June 2017 a populated draft was circulated for comment to the BoD. Following feedback further amendments were made to the current 2017/18 BAF, Appendix Two reflective of those changes and

including cross referencing with the BAF 16/17, Appendices, three and links between the Corporate Risk Register (CRR), Board and Board Sub Committees, Appendix four.

3 Next Steps

This is the first iteration of the BAF 2017/18 with work continuing with Executive Directors to strengthen and improve. Following approval by Audit Committee and BoD, the BAF will be implemented for 2017/18 reporting to the Audit Committee every quarter and to BoD twice a year.

Board sub-committees will continue to receive the individual risks pertinent to the remit of the Committee to enable discussion and recording of the assurances received by the meetings.

4 Actions

The BoD is asked to:

- Receive and approve the BAF 2017/18.

5 Monitoring Arrangements

Monitoring arrangements will be via Director of Corporate Governance (Board Secretary), Executive Directors Group (EDG), Board Committees and BoD.

6 Contact Details

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Shaping the Future
Trust Strategy and Strategic Planning Framework
Strategic Objectives 2017 to 2020

Strategic Aim: **Quality & Safety – We will provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing**

Strategic Objective A101
Effective quality assurance and improvement will underpin all we do
Risk A101: Failure to improve and maintain quality to required standards due to financial and transformational pressures.

Strategic Objective A102:
Deliver safe care at all times
Risk A102: Lack of understanding and applying the regulatory requirement of safe care – Safer Staffing.

Strategic Objective A103:
Provide positive experience and outcomes for service users
Risk A103: Failure to comprehensively capture the experience of our service users and take appropriate action.

Straetgic Objective A104:
Timely access to effective care
Risk A104i: Lack of agreed and appropriate targets across some services and lack of capacity to deliver across all services.
Risk A104ii: A lack of ability to influence our commissioners' intentions.

Strategic Aim: **People- We will promote a culture of collaboration, supporting people to work together to make a difference**

Strategic Objective A201:

We will manage change positively and effectively, ensuring support for staff

Risk A201: An inability to redeploy staff as a result of organisational change.

Strategic Objective A202:
We will develop a strategic approach to enable workforce transformation

Risk A202: Failure to develop a sustainable and integrated workforce strategy including a clear understanding of our current and future workforce requirements and how we work effectively with partners to deliver the strategy.

Stratgic Objective A203:
We will promote an effective culture of leadership and managements based on Trust values

Risk A203: Risk of disconnect between Trust values and operational delivery plus reputational risk from poor management practice.

Straetgic Objective A204:
We will prioritise the health and wellbeing of our employees

Risk A204: Risk of low motivation and morale will compromise staff motivation.

Strategic Aim: Future Services - We will develop excellent mental, physical and social wellbeing for the communities we serve through innovation, collaboration and sharing

Straetgic Objective A301:
Deliver interventions and support closer to general practice, neighbourhoods and embedded within other services.

Risk A301: Lack of primary care strategy

Straetgic Objective A302: Collaborate and work with partnerships to support shared aims of delivery quality care and support.

Risk A302: Lack of a Trust framework and a lack of understanding of the Trust's model for collaborative working.

Straetgic Objective

A303: **Provide effective community care and treatment**

Risk A303: Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration.

Strategic Objective A304: **Small provision of high quality inpatient services supported by effective alternative**

Risk A304: There is a lack of community provision in place as an alternative to inpatient care.

Strategic Aim: **Value for Money – We will provide sustainable sevices through ensuring value for money, reducing waste and unproductive time for our stafff**

Strategic Objective A401: **We will improve the productivity and efficiency of our services, maximising time spent with service users.**

Risk A401i: Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes.

Risk A401ii: Trust governance systems are not sufficiently embedded.

Strategic Objective A402:
We will reduce some of the services we provide in response to demand and market conditions

Risk A402: There is a lack of a public health-driven commissioning strategy.

Strategic Objective A403:
An estate plan that meets our needs

Risk A403: Interdependencies of reconfiguration of community and inpatient service restructure are not aligned with the Estate Plan and associated funding.

Strategic Objective

A404:	**Use technology to deliver new ways of working and new care models.**
Risk A403:	There is a lack of embeddedness of digital strategy and interdependencies with associated strategies.

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

AIM : QUALITY AND SAFETY - We will provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing.

Risk Ref No	Risk Description	Lead	Current Risk			Target Risk			Internal controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	Assurance Rating	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: Effective quality assurance and improvement will underpin all we do																			
A101	Failure to improve and maintain quality to required standards due to financial and transformational pressures	MH/LL	3	2	6	3	1	3	Implementation of Quality Improvement and Assurance Strategy. Trust-wide microsystems based quality improvement projects. Clinical Effectiveness Group established that monitors implementation of NICE guidance and Clinical Audit Programme. Quality Impact Assessment framework in operation, for all service redesign. Assurance framework relating to Care Standards established and monitored including Care Standards Peer Inspection Programme. Quality Schedule in place as part of National Contract with NHS CCG. Trustwide Action Plan addressing Regulatory Breaches (Musts) submitted to the CQC 2/5/17. Action plan expanded to include "Shoulds" and shared with CQC at quarterly Engagement meetings. Mini CQC Quality Summit with Clover Group and CCG 29/06/17. Assurance meetings betwen Care Standards team and Clover Group monthly. Executive led monthly Task & Finish Oversight Group (monitoring progress against these actions) commenced June 2017 for 6 months. A progress reporting system is in place to Mental Health Act Committee (MHAC) Trust Management Group (TMG) and QAC/Board. Monthly CQC Engagement Meetings commenced (quarterly to discuss comprehensive action plan and two meetings per quarter to discuss specific issues.	QI&A Strategy not fully implemented. Care Standards Peer Inspections (to include work towards "Outstanding" and recommendations for RCOP accreditation) not yet commenced. Linking with Mocrosystems where appropriate. Quality Assurance that the Regulatory Breach (Musts) and Should Actions (via CSPIs) are underway. This is an on-going process as actions are reported as "Complete" by services. This process includes the Provider and Well Led action plans. The overall rating for the Safety Domain "Requires Improvement". The rating for Rehabilitation Wards, Health Based Place of Safety and The Clover Group is "Requires Improvement"	Care Standards Peer Inspection Quality Assurance Reports. Clinical Effectiveness Group Assurance Reports. Progress reports on QI&A strategy implementation. Outputs from quarterly Service Reviews with all directorates. Oversight of local CQC action plans managed by Directorates reporting to the Task & Finish Oversight Group led by Executive Director / Care Standards Team. Governance arrangements to ensure performance management of Action Plan in place. Trust wide reporting via MHAC, TMG, QAC/Board. Care Standards Manager quality assurance meetings monthly with Clover Group.	Monthly Quarterly June 17 and monthly to Nov 17 Quarterly	CQC Comprehensive Inspection November 2016. Overall Rating "Good" Care Quality Commission inspection reports. Trustwide Action Plan addressing Regulatory Breaches (Musts) and "Shoulds" acknowledged and shared with CQC at quarterly Engagement meetings. 360 Assurance report on Quality Governance. Quality Schedule progress reports from the CCG. NHS Improvement segmentation and performance reports on Single Oversight Framework. Adult Social Care Inspection Reports for Buckwood View , Birch Ave, Mansfield View and Woodland View all "Good". Wainwright Crescent "Requires Improvement." MHA Monitoring visits and reports from CQC.	March 17 Quarterly April 17 As completed As completed	Regulatory Breaches and Should actions, action plan in place Limited Assurance, action plan in place agreed with Internal Audit. Action plans in place	Limited	QI&A Strategy to be fully implemented. Care Standards Peer Inspections Options paper to EDG Aug 2017 Must Do and Should Actions: majority to complete by Nov 2017 with some estates work spanning to 2020. Safety Domain given high priority. Medical Director appointed as Safety Champion. Investment in Patient Safety governance resources. Action plan in place. Quality Governance actions from 360 Assurance report to be completed. Action plans in place and monitored to closure for Adult Socila Care inspections and MHA Monitoring visits by the CQC.	LL/ MH/ MS	March 2018 October 2017 Nov 2017 2020 Nov 2017 Sept 2017

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

Risk Ref No	Risk Description	Lead	Current Risk			Target Risk			Internal controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: Deliver safe care at all times																			
A102	Lack of understanding and applying the regulatory requirement of safe care - Safer Staffing	MH/LL	4	2	8	2	2	4	Ward staffing capacity & capability is managed at Directorate level by the Ward Managers & Senior Nurses and corporately the Deputy Chief Nurse chairs a monthly Safer Staffing Group. Safer Staffing is reported to Ward/Directorate, EDG & Board monthly. The new ward E-Rostering system (Allocate) is being implemented. EDG have agreed the ToRs for the new Exec-led Effective Staffing (Governance) Group. QIA Procedure in place. Implementation of Quality Improvement and Assurance Strategy.	All registered nurse ward staffing levels to be signed off by the Executive Director of Nursing. E-Rostering modules being rolled out and tested, not all fully operational yet.	Safer Staffing Reports to QAC/WODC. QIA procedure in place.	Monthly	Internal Audit Reports on Safer Staffing Significant Assurance	Feb 2017	SafeCare module not fully operational. A lack of patient demand and staff capacity management & reporting in realtime.	Limited	Registered nurse ward staffing levels to be signed off. Recruitment is progressing to address nurse gaps as a rolling programme. E-Rostering modules to be rolled out and operational after testing. Safer Care module to be fully operational including patient demand and staff capacity management reporting in real time.	LL	Sept 2017
Strategic Objective: Provide positive experiences and outcomes for service users																			
A103	Failure to comprehensively capture the experience of our service users and take appropriate action	MH	3	2	6	2	1	2	Implementation of Service User Engagement Strategy. Service users involved in microsystem projects within teams. Service user recruited within QI team to strengthen engagement across Trust.	Service User Engagement Strategy Implementation Plan not fully embedded.	Regular Service User Engagement Group Assurance Reports to EDG & QAC	Quarterly	Care Quality Commission inspection reports.	March 17		Significant	Service User Engagements Strategy Implementation Plan to be monitored regularly by SUSEG	MH	Sept 2017
Strategic Objective: Timely access to effective care																			
A104i	Lack of agreed and appropriate targets across some services and lack of capacity to deliver across all services.	MH/CC	3	3	9	1	4	4	Clinical Effectiveness Group established that monitors implementation of NICE guidance. Care standards in line with CQC requirements. CQINNs. Monitoring national waiting times (EIS/IAPT). Quality standards within CCG contract.	Inconsistent clinical management structure, e.g. temporary staff. ClikView system (performance mgt tool) not yet established across all service areas. Greater clarity and shared Trust understanding of standards.	Clinical and Corporate Monthly Performance Report to FIC, QAC, EDG and Board, e.g. Safety Dashboard, financial performance Quarterly Service Reviews. Peer inspections, udpates and action plans reporting to CQC Oversight & Performance Task Group. Oversight by QAC and TMG. Performance reports to EDG/ QAC/BoD	Monthly Quarterly Monthly Monthly Monthly	Reporting via Unify for Early Intervention Service (EIS) and IAPT. Monthly report (re targets) to NHS England. Contract Management Group meets monthly and Board bi-monthly to review investment and performance. Quality Performance Review Group	Monthly Monthly Monthly bi-monthly Monthly	Prioritise NICE guidelines for implementation.	Significant	Clinical restructure underway for city wide service provision. CliKView system to be established across all services.	CC CC	Oct 17 Apr 18

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

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			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: Timely access to effective care																			
A104ii	A lack of ability to influence our commissioners intentions	MH/CC	4	2	8	2	2	4	Trust working with commissioners on transformation agenda (led by LDS & MH Delivery Boards with key clinical individuals working into project groups). Joint Director of Strategic Commissioning post in place.	Restructuring of governance structure in place for transformation agenda. Lack of city-wide dementia strategy needed to support the future of Trust services.	Contract update report provided to Business Planning Group (as subgroup of EDG). Reports to Finance and Investment Committee on contract performance.	2-weekly Monthly	Contract Management Group (NHS SCCG & SCC) meet monthly and Board bi-monthly. Board to Board meetings with NHSSCCG and SYHA. Commissioning intentions agreed with CCG. Escalation procedures in place. Quarterly review with NHS I on contract performance. Contract monitoring with NHS England. Contract monitoring with SCC.	Monthly As & when Annually Quarterly as & when Monthly	No underpinning contract with SCC.	Significant	Governance structure being developed by Chair of Delivery Board. Transformation project addressing lack of city-wide dementia strategy. CMG meet with SCC/CCG to develop and agree a new contract.	KT KT CC	Nov 2017 Oct 2017 Mar 2018

AIM : PEOPLE - We will promote a culture of collaboration, supporting people to work together to make a difference

Risk Ref No	Risk Description	Lead	Current			Target			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: We will manage change positively and effectively ensuring support for staff																			
A201	An inability to re-deploy staff as a result of organisational change	DW	3	2	6	2	2	4	Redeployment Co-ordination Group established and redeployment process in place.		Redeployment Co-ordination Group reports to Vacancy Control Panel (VCP). VCP exception report contained within Workforce Report to WODC.	Monthly Quarterly				Significant		DW	
Strategic Objective: We will develop a strategic approach to enable workforce transformation																			
A202	Failure to develop a sustainable and integrated workforce strategy including a clear understanding of our current and future workforce requirements and how we work effectively with partners to deliver the strategy	DW	4	2	8	2	2	4	Bank Staffing Group, Agency and Off Payroll Group, Safer Staffing Group, Rostering to be overseen by the Effective Staffing Strategic Group. Joint group with nursing to review specific challenges e.g. qualified nursing. Effective Staffing Strategic Group (ESSG) operational from August 2017. Health Eduction England annual workorce planning return.	Plans not yet fully developed to address medium to long term. Updated Workforce Strategy being finalised for July 2017 WODC. Workforce Strategy Action Plan to be developed and updates provided to WODC.	ESSG report to WODC From Oct 2017 reports to WODC on Workforce Strategy Action Plan.	quarterly	Workforce In-year Monitoring Return to NHS Improvement. Follow up meeting with all returning office for moderation by Health Education England. Contract monitoring report to NHS SCCG . Internal Audit report on Safe Staffing gave "Significant Assurance".	annually annually monthly May 2017	New reporting system from May 2017. Workforce Strategy action plan not yet in place	Significant	Complete as required. Following WODC approval of Workforce Strategy Action Plan in July 2017, action plan to be developed in Oct 2017 for monitoring.	DW	Dec 2017

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

Risk Ref No	Risk Description	Lead	Current			Target			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: We will promote an effective culture of leadership and management based on Trust values																			
A203	Risk of disconnect between Trust values and operational delivery plus reputational risk from poor management practice.	DW	3	2	6	2	2	4	Review of and learning from employment tribunals. Leadership programme agreed via EDG. Good engagement with Schwartz Rounds. High PDR compliance. Coaching service established. Microsystems developed and involved in projects. Values based recruitment. Annual Staff Survey, Friends and Family Test, Workplace Well Being quarterly report by exception reported to HR SMT and WODC.	Lack of systematic review and follow up following Employment Tribunals. Implementation still required for a number of modules for the Leadership programme.	Included in Workforce report to WODC and where appropirate reported to Board.	quarterly	Friends and Family Test		Leadership programme in early stages. Link outcome from FFT with annual staff survey.	Significant	Roll out of programme under development. Needs to be included Staff Survey Action Plan	DW	Dec 2017 Oct 2017
Strategic Objective: We will prioritise the health and wellbeing of our employees																			
A204	Risk of low motivation and morale compromises staff motivation	DW	3	3	9	2	2	4	Numerous suppport and engagement Groups in place including Health & Wellbeing Group, Workplace Wellbeing, IAPT. A CQUIN for health and welll-being. Physio Med service in place for MSK issues. Clarity of communication and consistency of Trust messages via a number of mechanisms including Chief Executive Letter, directorate communication structures, Communications Digest.	Staff Survey Action Plan to be signed off by WODC 28 July 2017. Implementation of Psychological Service support.	Progress against Staff Survey Action Plan reported to WODC. Staff survey action plan reported into Board with WODC minutes and/or WODC signiciant issues report.	bi-annually quarterly	Progress on staff survey action plan monitored by Contract Management Board of NHS SCCG.	monthly	Lack of psychological support for staff.	Significant	Review Staff Survey Action Plan and provide assurance via WODC. IAPT to provide details of services via SHSC.	DW DW	31 July 2017 Dec 2017

AIM : FUTURE SERVICES We will develop excellent mental, physical an social wellbeing for the communities we serve through innovation, collaboration and sharing

Risk Ref No	Risk Description	Lead	Current			Target			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: Deliver interventions and support closer to general practice, neighbourhoods and embedded within our services																			
A301	Lack of Primary Care Strategy	CC	3	3	9	2	2	4	EDG met (June 17) to begin the process of developing a primary care strategy.	SHSC Primary Care strategy not yet in place which will encompass both our future intentions and how current services provided by SHSC can be more primary care facing.						Significant	Board strategy development session. EDG strategic discussion. Board Development session. Draft strategy to Board.	CC	July 2017 July 2017 Aug 2017 Oct 2017
Strategic Objective: Collaborate and work with partners to support shared aims of delivering quality care and support																			
A302	Lack of a Trust framework and a lack of understanding of the Trust's model for collaborative working	CC/PE	2	3	6	2	2	4		No partnership engagement framework in place.	Individual reports to EDG Strategy sessions and TMG regarding service development opportunities.	As and when				Significant	Production of Partnership Engagement Framework.	CC	Dec 2017

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

Appendix 2

Risk Ref No	Risk Description	Lead	Current			Target			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: Provide Effective community care and treatment																			
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration.	CC	3	4	12	2	2	4	Clear CMHT reconfiguration implementation plan in place with agreed timescales.	Staffing issues ie temporary posts/sickness/vacancies which can undermine quality during the transitional period.	Reconfiguration update to EDG. Mobilisation update to EDG. Safety dashboard to QAC/BOD and full performance report to BOD.	Monthly Jul 17 Monthly	Contracting meeting with NHS SCCG	Monthly		Significant	Organisational Restructure Policy in place	CC	Nov 2017
Strategic Objective: Provision of high quality in-patient services supported by effective alternatives																			
A304	There is a lack of community provision in place as an alternative to inpatient care.	CC	3	3	9	2	3	6	A review has been commissioned of step-up and step-down beds.	Lack of assurance that previous decisions made to develop PD and Home Treatment services produced intended outcomes.	Report on crisis house to EDG and FIC. Report on Wainwright to EDG & FIC.	Aug 17 Oct 17	Contracting meeting with NHS SCCG	Monthly		Significant	Review of PD and Home Treatment services to be undertaken.	CC	Oct 2017
AIM : VALUE FOR MONEY We will provide sustainable services through ensuring value for money, reducing waste and unproductive time for our staff																			
Strategic Objective: We will improve the productivity and efficiency of our services																			
A401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes	PE	4	2	8	3	2	6	Historical strong financial management Financial Plan including CIP Governance and reporting arrangements in place through EDG via TOG and BPG	Some weakness in Financial governance at Directorate level	Monthly finance report CIP & Divestment reporting (TOG)	Monthly finance report CIP & Divestment reporting (TOG)	Internal Audit - Significant assurance on financial management	Jun-17	Lack of understanding of productivity across all services	Significant	Productivity KPI and/or benchmark on Cost for all Clinical and Corporate services	PE	Oct-17
Strategic Objective: We will improve the productivity and efficiency of our services																			
A401ii	Trust governance systems are not sufficiently embedded	KT	3	4	12	3	2	6	Board Sub Committees established and operational with revised ToRs. Significant issue reports following Committee meetings. Reviewed and revised the Risk Management Strategy. Executive Directors portfolios embedded Policy Governance Group.	Board Assurance Review. Clarity of assurance responsibilities within ToRs for each Board Committee. Definition of the quality of assurances required for the Board. Utilisation of NEDs expertise. Appropriate challenge and performance management at operational group level of information prior to presentation to Board Committees.	Minutes of meetings Annual Report Annual Governance Statement Provider Licence Self certification Policy Governance Group	monthly/bi monthly/quarterly Annually Annually Annually Monthly	Head of Internal Audit Opinion CQC Well Led and comprehensive review Internal audits NHS Improvement Review Meetings	annually 3-yearly Throughout year Quarterly	Fulfilment of Committee ToRs Fulfilment of Committees and Board assurance responsibilities Embedment of assurance systems and process	Limited	Action plan prepared with recommendations from 360 Assurance Trust Committee Governance Follow-Review	MS	Mar-18
Strategic Objective: We will adapt some of the services we provide in response to demand and market conditions																			
A402	There is a lack of a public health-driven commissioning strategy.	CC	3	3	9	2	3	6	Performance data provides clear indications of needs/trends/gaps that enable forward thinking and influencing of partners. Implementation of 5 Year Forward View.	No systems currently in place to ensure that performance data/intelligence is fed into relevant delivery boards.	Report of implementation of 5 Year Forward View to EDG and Board. Tranformational Operational Group (TOG) reports on service development plans based on 5 year forward view.	Jun-17			Lack of understanding of intelligence requirements across all services	Moderate	Governance structure being developed by Chair of Delivery Board (ensuring key personnel are included and influence strategy). Development of ClikView to capture realtime data.	KT	Nov-17

SHSC BOARD ASSURANCE FRAMEWORK 2017/18

Risk Ref No	Risk Description	Lead	Current			Target			Controls	Gaps in Control	Sources of Assurance				Gaps in Assurance	RAG Rating of Gaps	Actions to address gaps in controls and	Actions Assigned	Target Date
			C	L	R	C	L	R			Internal	Rec'd	External	Rec'd					
Strategic Objective: An Estate plan that meets our needs																			
A403	Interdependencies of reconfiguration of community and in-patient service restructure are not aligned with the Estate plan and associated funding.	PE	4	3	12	3	2	6	Approved Estates Strategy Governance and reporting arrangements in place through EDG via TOG>BPG Capital Board oversight Board assurance via FIC and sale of assets approved via BoD Estates Capacity in place to deliver strategy Stakeholders meetings held and/or arranged with all relevant community and inpatient service managers	Capital funding requirements for ACR Phase 2 best estimates only Estates related funding requirements for community restructure not yet clear and will link to disposal and acquisition of properties Overall potential impact on capital and revenue not yet clear Strategy implementation plans not fully developed - Gaps around Estate utilisation and maximisation	Capital Board minutes TOG minutes + Checkpoint Reports and Status Reports Estates Strategy implementation Gantt chart(s)	Monthly Starting July 2017 Draft V1 available	External project management (Arcadis) reports to Capital Board re. ACR Phase 2	monthly	Full development of implementation plan TOG reporting/ governance processes Outcomes of stakeholder meetings to progress community reconfiguration Tendered capital cost for ACR Phase 2 Estimated + tendered costs for estates solutions for community reconfiguration Overall financial appraisal (capital and revenue)	Moderate	Complete implementation plan TOG governance processes due to start July 2017 Stakeholder meetings to progress community reconfiguration started Construction tendering informs actual capital funding requirement for ACR Phase 2 Plan for community restructure estates solutions will inform funding requirements (and disposals/ acquisitions) via a Business Case Combination of both the above will inform overall capital & revenue impacts	PE	July 2017 (TBC) July 2017 June 2017 Feb 2018 (TBC) Q3 Q4
Strategic Objective: Use technology to deliver new ways of working and new care models																			
A404	There is a lack of embeddedness of digital strategy and interdependencies with associated strategies	PE	3	4	12	2	4	8	IT strategy in place (Dynamic) Digital Transformation and Business Planning governance frameworks and mechanisms.	Authority of Head of the PMO and PMO staff to instil compliance with these mechanisms. Compliance behaviour.	Data & Information Governance Board and Business Planning Group		Auditors (specific audits) and NHS England (Digital Maturity Toolkit)		External Assurance on IT Strategy (IA)	Significant	Improve engagement with Digital Transformation Strategy	PE	Review 12/17

Board Assurance Framework 2017-18

Risk Rating Matrix

The Board Assurance Framework (BAF), Appendix 3, 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

Key to Assurance Rating:

	Full Assurance
	Significant Assurance
	Moderate Assurance
	Limited Assurance
	No Assurance

Appendix 3

Board Assurance Framework (BAF) Refresh 2017/2018
Cross Referenced with 2016/17 BAF

2016/17		2017/2018	
BAF Risk Number		**BAF Risk Number**	
1.1	Risk that Quality of Care provided falls below expectations and/or standards	A 101	Failure to improve and maintain quality to required standards due to financial and transformational pressures
1.2	Risk that service users' physical health needs are not being met effectively	A 101	Failure to improve and maintain quality to required standards due to financial and transformational pressures
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	A 103	Failure to comprehensively capture the experience of our service users and take appropriate action
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	A 102	Lack of understanding and applying the regulatory requirement of safe care
2.1	Risk that the Trust will not effectively gather and utilise service user feedback to inform quality improvement	A 103	Failure to comprehensively capture the experience of our service users and take appropriate action

2016/17		2017/2018	
BAF Risk Number		**BAF Risk Number**	
3.1	Risk that service users will have to wait longer than expected to receive services (ARC and Rehab)	A 101	Failure to improve and maintain quality to required standards due to financial and transformational pressures
3.2	Missing from 3.2 in the 16/17 BAF		
3.3	Risk that the Trust will not work collaboratively and in partnership with others to achieve its objectives	A 302	Lack of a Trust framework and a lack of understanding of the Trust's model for collaborative working
4.1	Risk that the Trust will not continue to be financially viable and that strategic plans will not deliver the required financial savings	A 401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes
4.2	Missing from 16/17 BAF		
4.3	Risk that Trust governance systems may not be sufficiently robust	A 401ii	Trust governance systems are not sufficiently embedded
4.4	Risk that terms of the Provider Licence may be breached	A 401ii	Trust governance systems are not sufficiently embedded
5.1	Potential risk of poor leadership across Trust which inhibits meaningful staff engagement	A 203	Failure to engage staff positively to embrace change Disconnect between strategic interventions, leadership and our operational need

2016/17		2017/2018	
BAF Risk Number		**BAF Risk Number**	
5.2	Risk of poor staff wellbeing	A 204	The health and wellbeing of employees maybe jeopardised if the Trust places too greater emphasis on external demands
5.3	Potentially insufficient capacity to deliver all mandatory training across Trust to improve attendance and monitoring of Mandatory Training	See June 2017 Trust Board Public Risk Profile paper 06 - attached	

Links between Board Assurance Framework, Corporate Risk Register and Board sub-committees 2017/18

BAF Risk No.	Risk Description	Corporate Risk Register Number(s)	Board/ Sub-committee(s)
A101	Failure to improve and maintain quality to required standards due to financial and transformational pressures	3679 3788	QAC QAC
A102	Lack of understanding and applying the regulatory requirement of safe care – Safer Staffing	2206 3768	QAC WODC
A103	Failure to comprehensively capture the experience of our service users and take appropriate action	2125	QAC
A104i	Lack of agreed and appropriate targets across some services and lack of capacity to deliver across all services		
A104ii	Lack of ability to influence our commissioners' intentions	3717 3718	FIC FIC
A201	An inability to redeploy staff as a result of organizational change		
A202	A failure to develop a sustainable and integrated workforce strategy including a clear understanding of our current and future workforce requirements and how we work effectively with partners to deliver the strategy.	2206	QAC WODC
A203	Risk of disconnect between Trust values and operational delivery plus reputational risk from poor management practice	2231	WODC
A204	Risk of low motivation and morale compromises staff motivation	2310	WODC
A301	Lack of primary care strategy		
A302	Lack of Trust framework and a lack of understanding of the Trust's model for collaborative working		
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration	3322 3439	QAC/BOD QAC
A304	There is a lack of community provision in place as an alternative to inpatient care		
A401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes	2161 2175	FIC FIC

A401ii	Trust governance systems are not sufficiently embedded	3333 2231 2948	BoD WODC AC
A402	There is a lack of a public health-driven commissioning strategy		
A403	Interdependencies of reconfiguration of community and inpatient restructure are not aligned with the estate plan and associated funding		
A404	There is a lack of embeddedness of digital strategy and interdependencies with associated strategies	3659	QAC

Key:

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