BOARD OF DIRECTORS MEETING (Open)

Date: 14 February 2018

09

TITLE OF PAPER	Board Assurance Framework (BAF)
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	Discussion and approval

OUTCOME	To provide assurance to the Board that utilising the Board Assurance Framework (BAF), complemented by the risk management Strategy, the Trust has systematically managed the principal risks identified in achieving its objectives.
TIMETABLE FOR DECISION	14 February 2018
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management arrangements Directorate Risk Registers Risk Management Strategy Shaping the Future, the Trust Strategy & Strategic Planning Framework 2017-2020
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Value for Money Strategic Objective: We will provide sustainable services through ensuring value for money, reducing waste and unproductive time for staff BAF Risk No: A401ii BAF Risk Description: Trust governance systems are not sufficiently embedded.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	NHS Improvement's regulatory framework Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Implications of individual risks are highlighted in the BAF. The BAF enables the Trust to satisfy its regulatory requirements and provides assurance for the Chief Executive to sign the Annual Governance Statement.
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	6 February 2018

SUMMARY REPORT

Report to: Board of Directors

Date: 14 February 2018

Subject: Board Assurance Framework (BAF) 2017/18

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

Author: Sam Stoddart, Deputy Board Secretary

1 Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
	✓	✓	✓		

2 Summary

In March 2017 following a comprehensive CQC Inspection the Trust received a good rating. The Trust now aspires to be outstanding and this paper details a number of corporate governance actions to support this and meet the requirements of:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance

- NHS Improvement - Development reviews of leadership and governance using the well-led framework, https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf requires the Trust to have a board assurance framework (BAF) and risk registers in place which are assessed by the board on a quarterly basis as a minimum.

- Securing an improved Head of Internal Audit for 2016/17 opinion and

- Mitigate strategic objective 'we will improve the productivity and efficiency of our services' and BAF Risk A401ii – Trust Governance systems are not sufficiently embedded.

3 Next Steps

The BAF is populated utilising the Trust's Ulysses Risk Management System which enables local, dynamic, auditable directorate updates which are quality assured by the respective Executive leads. Future BAF reports to the Audit Committee will identify papers presented to Board Committees which provide assurance against the strategic

and delivery objectives within the Strategic Planning Framework 2017-2020 and evidence mitigation of the strategic risks contained within the BAF including highlighting the BAF risks for which no reports have been received.

The revised Risk Management Strategy approved in October 2017 by the Audit Committee defines the nature of the BAF and the frequency with which it should be reviewed by the Board and its committees, i.e. on a quarterly basis. Each Board Committee is responsible for reviewing those BAF risks attributed to it with a view to confirming sufficient assurance has been gained that risks are being managed and mitigated. Any concerns Board Committees have in relation to the BAF would also be recorded in the 'significant issues' report presented to the Board.

The Board utilises the BAF to seek assurance by identifying risks to achieving the strategic objectives of the Trust and details controls, assurances and actions to mitigate the risks. Whilst each risk in its own right does not receive an overall assurance rating, every control within each risk is assigned an assurance rating.

In the process of updating, the 20 risks contained in the BAF, Appendix 1, continue to be refined, with efforts taken to provide greater specificity. A summary of all amendments made since presented to the Committee in October 2017 is provided in Appendix 2 with definitions available at Appendices 3 and 4 and Appendix 5 detailing those Committees to which BAF risks are linked and links with risks on the Corporate Risk Register (CRR).

Currently there are 72 controls attributed to the 20 BAF risks compared to 69 in the previous iteration. Additionally there are 43 identified gaps in control and 29 identified gaps in assurance compared to 45 gaps in control and 16 gaps in assurance in the version presented in November 2017. Of the 20 risks on the BAF, five assign significant assurance to all their controls A201, A303, A304, A401i and A404.

Of the 45 actions included in the previous iteration of the BAF, 11 have been completed and closed covering seven risks. There have been ten new actions added to six risks and fifteen actions covering eight risks have had their target dates extended.

The above evidences a marginal increase in assurance that the actions taken support achievement of the Strategic Objectives of the Trust.

The BAF and corporate risks will continue to be updated in line with feedback from this committee and a full review of the BAF will take place in line with reporting requirements.

Summary analysis

The Board Committees support the internal assurance mechanisms employed in the Trust. The following Board Committees have reviewed the BAF during the last quarter.

- Quality Assurance Committee (QAC) 27 November 2017
- Finance and Investment Committee (FIC) 22 January 2018
- Audit Committee (AC) 23 January 2018
- Workforce and Organisation Development Committee (WODC) 30 January 2018

4. Required Actions

The Board is asked to:

a) Receive and approve the BAF.

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

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

5. Monitoring Arrangements

The BAF and Corporate Risk Register are monitored by the Director of Corporate Governance (Board Secretary). However, it is the responsibility of Board Committees to ensure that they have due oversight of those risks for which they have responsibility and that the papers which are brought before them provide sufficient assurance that risks are being addressed and managed.

6. Contact Details

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Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
A101i	Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance). Executive Director of Nursing, Professions & Care Standards	Control 1: new internal assurance added Control 2: point 4 updated, gaps in control revised (greater specificity), internal assurance updated, internal assurance added, external assurance expanded and external assurance removed (Wainwright Crescent). Control 3: new control added, gap in control (revised governance structure not fully implemented) removed as structure implemented, 2nd internal assurance expanded, MHA Compliance programme removed from internal assurance as now a control, gaps in assurance amended to make more specific to control. Control 4: points 1 and 2 revised and updated, point 3 now in place, gap in control 1 updated, 2 new forms of internal assurance added, assurance rating increased to moderate from limited Control 5: gap in assurance added Control 6: internal assurance removed Control from previous iteration closed – no longer applicable (Care Standards & Quality Assurance Team attend Clover Group SMT) Action 1: progress added and target date extended by 2 months Action 2: detail expanded, progress added and target date extended by 4 months Action 3: progress added and target date extended by 3 months Action 4: progress added and target date extended by 1 month Action 5: action expanded and target date extended by 4 months Action 6: detail expanded for greater clarity Action 7: detail expanded to reflect current situation and progress added and target date extended by 4 months Action 8: no change Actions closed: now complete a) Regulatory breaches are to be completed by end Nov 17 (final status report to be received in Jan 18 TMG & QAC and Feb 18 Board. b) Director of Quality appointed to and in post from 1/4/18. c) Joint development plan with City Council, NHS Sheffield CCG and Sheffield Children's NHS FT agreed Dec 17. 5 controls all providing moderate assurance.

Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
A101ii	Inability to provide assurance regarding improvement in the quality of patient care. Executive Medical Director	Control 1: gap revised, 2nd internal assurance expanded, external assurance added Control 2: internal assurance added plus 3rd internal assurances revised for greater clarity, external assurance refined Action: revised to reflect revision to gap in assurance and target date extended by 1 month 2 controls each providing moderate assurance.
A102i	Failure to deliver safe care due to insufficient numbers of appropriately trained staff. Executive Director of Nursing, Professions & Care Standards	Control 1: no change Control 2: no change Control 3: no change Action 1: progress added and target date extended by 2 months to reflect change in circumstance Action 2: description expanded, responsible person changed, progress added and target date extended by 2 months. Action 3: progress added and target date extended by 1 month. Action 4: description expanded, progress added. 3 controls, 2 providing limited assurance one providing moderate assurance.
A102ii	Inability to provide assurance regarding improvement in the safety of patient care Executive Medical Director	Control 1: no change Control 2: external assurance expanded for greater clarity Action 1: no update 2 controls, one providing limited assurance, one providing significant assurance.
A103	Failure to comprehensively capture the experience of our service users and take appropriate action. Executive Medical Director	Control 1: no change Control 2: internal assurance given greater clarity Control 3: internal assurance added Control 4: control and internal assurance refined to give greater clarity, external assurance expanded and new external assurance added. Gap in assurance added and assurance rating reduced to limited from significant Action 1: no update Action 2: new action 4 controls, 2 providing moderate assurance, 1 providing significant assurance and 1 providing limited assurance

Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
A104i	Failure to achieve national performance targets for Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP) services Executive Director of Operations	Control 1-5: no change Action 1: new action Action closed (ClikView system) as now complete 5 controls, 3 providing significant assurance, 2 providing moderate assurance
A104ii	A lack of ability to influence our Commissioner's intentions. Executive Director of Operations	Control 1-4: no change Action 1: target date extended by 1 month to reflect multiple sign offs Action 2: progress added Action 3: no update 4 controls, 2 providing moderate assurance, 2 providing significant assurance
A201	An inability to re-deploy staff as a result of organisational change. Director of Human Resources	Gap in assurance added Action added 1 control providing significant assurance
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. Director of Human Resources	Control 1: no change Control 2: internal assurance added and gap in assurance added, assurance rating reduced to moderate Control 3: gap in assurance added, assurance rating reduced to moderate Control 4: internal assurance added Control 5: control expanded Control 6: internal assurance added, assurance rating reduced to moderate Action: closed as Workforce Strategy Action plan signed off by November 2017 Board. Two new actions added to address gaps in assurance 6 controls, 3 providing significant assurance, 3 providing moderate assurance
A203	Risk of disconnect between Trust values and operational delivery, plus reputational risk from poor management practice.	Control 1: internal assurances revised Control 2: gap in control expanded. Control 3: no change Control 4: internal and external assurance added Control 5: gap in control added, internal assurance added Control 6: no change

Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
	Director of Human Resources	Control 7: gap in assurance added Control 8: no change Control 9: no change Control 10: new control Action 1: progress added Action 2: progress added Action closed re coaching reports – added to internal assurance 10 controls, 6 providing significant assurance, 4 providing moderate assurance
A204	Risk of low motivation and morale compromises staff motivation. Director of Human Resources	Control 1: internal assurance 'psychological service' removed, now new control Control 2: new internal assurance added Control 3: new internal assurance added Control 4: no change Control 5: new internal assurance added Control 6: new control Control 7: new control Control 8: new control 8 controls, 1 providing full assurance, 6 providing significant assurance, 1 providing moderate assurance
A301	Lack of Primary Care Strategy. Executive Director of Operations	Control: no change Action: progress added and target date extended by 2 weeks to reflect change to scheduled meeting 1 control providing moderate assurance.
A302	Lack of a Trust framework and a lack of understanding of the Trust's model for collaborative working Executive Director of Operations	Control: no change Action closed (production of partnership engagement framework) 3 new actions created, one of which supersedes the closed action. 1 control providing limited assurance
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration. Executive Director of Operations	Control: no change Action: progress update 1 control providing significant assurance

Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
A304	There is a lack of community provision in place as an alternative to inpatient care. Executive Director of Operations	Control 1: no change Control 2: no change Action 1: progress update 2 controls both providing significant assurance
A401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes. Executive Director of Finance	Control 1-3: no change Action 1: progress update and target date extended by 3 months to reflect clinical directorate restructure timescales Action 2: no change 3 controls all providing significant assurance
A401ii	Trust governance systems are not sufficiently embedded. Chief Executive (Director of Corporate Governance)	Control 1: gap in Assurance amended to show 'moderate' Head of Audit opinion and assurance rating increased to moderate from limited Control 2: control updated and gap in control removed, gap in assurance updated and assurance rating reduced to limited from moderate Control 3: gap in assurance added Control 4: no change Action 1: progress update and timescale extended by 2 months Action 2: progress update 2 new actions Action closed (Risk Management Strategy) as approved and now a control Action closed (IA Audit) as report presented and new action created 4 controls, 2 providing limited assurance, 1 providing moderate assurance and 1 providing significant assurance
A402	There is a lack of a public health-driven commissioning strategy. Executive Director of Operations	Controls: no change Action: description revised and action updated 3 controls all providing moderate assurance
A403	Interdependencies of reconfiguration of community and inpatient service	Control 1: no change Control 2: no change Control 3: greater clarity given to gaps in control, additional internal assurance added, gaps

Risk Number	Risk Description and Executive Lead	Changes and Assurance Provided
	restructure are not aligned with the Estate Plan and associated funding. Executive Director of Finance	in assurance revised and increased. Control 4: assurance rating increased to 'full' Control 5: gap in assurance added Action 1: description expanded and progress added Action 2: description expanded and progress added Action 3: description expanded and progress added Two actions closed. First 'to clarify estates-related funding requirements' because resources have been diverted to deliver an interim solution for CMHT reconfiguration. Medium and long term solutions are as per wider interdependencies. Second 'Ensure TOG governance processes are embedded' because addressed in other actions. 5 controls, four providing moderate assurance, 1 providing full assurance
A404	There is a lack of embeddedness of digital strategy and interdependencies with associated strategies. Executive Director of Finance	Control 1-2: no change Action 1: progress added and target date extended by 2 months' to reflect further actions required. 2 controls both providing significant assurance

BAF Definitions **Appendix 3**

Controls:	The many different things that are in place to mitigate risk and assist in the delivery of security objectives. They should make a risk less likely to happen or reduce its effect if it does. The Chartered Institute of Internal Auditors defines a control as "any action taken by management, the board and other parties to manage risk and increase the likelihood that established objectives and goals will be achieved. Management plans, organises and directs the performance of sufficient actions to provide reasonable assurance that objectives and goals will be achieved." The Board should consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
Assurance:	Evidence obtained from a variety of sources including management reports, minutes, internal and external audit reports that controls are operating effectively, routinely applied and the underlying objective will be achieved.
Gap in control:	This exists where adequate controls are not in place or where collectively they are not sufficiently effective.
Gap in assurance:	This exists where there is a failure to gain evidence that the controls are effective.
Actions:	Wherever gaps in control or assurance are identified, action plans must be in place and allocated to executives to ensure the situation is remedied.

Reference: A Simple Rules Guide for the NHS: Board Assurance Frameworks, Good Governance Institute 2009

Reference: Chartered Institute of Internal Auditors https://www.iia.org.uk/resources/control/

Assurance Ratings **Appendix 4**

	Full Assurance	The system of internal control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
	Significant Assurance	There is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.
	Moderate Assurance	There is a sound system of internal control. However, inconsistent application of controls put the achievement of the organisation's objectives at risk.
	Limited Assurance	Weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.
	No Assurance	Weaknesses in control, or consistent non-compliance with key controls could result (have resulted) in failure to achieve the organisation's objectives in the areas reviewed.

Ref: 360 Assurance

Appendix 5

Links between Board Assurance Framework, Corporate Risk Register and Board Committees 2017/18

BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee(s)
A101i	Inability to provide high quality care due to failure to meet regulatory standards (registration & compliance).	3322 3679 3788	QAC QAC QAC
A101ii	Inability to provide assurance regarding improvements in the quality of patient care.	3322 3831	QAC QAC
A102i	Failure to deliver safe care due to insufficient numbers of appropriately trained staff.	3858	WODC
A102ii	Inability to provide assurance regarding improvement in the safety of patient care.	3322	QAC
		3679	QAC
A103	Failure to comprehensively capture the experience of our service users and take appropriate action		QAC
A104i	Failure to achieve national performance targets for IAPT and EIS.		QAC
A104ii	Lack of ability to influence our commissioners' intentions		QAC
A201	An inability to redeploy staff as a result of organisational change		WODC
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.		WODC
A203	Risk of disconnect between Trust values and operational delivery plus reputational risk from poor management practice		WODC
A204	Risk of low motivation and morale compromises staff motivation		WODC
A301	Lack of primary care strategy		BoD
A302	Lack of Trust framework and a lack of understanding of the Trust's model for collaborative working		BoD
A303	Insufficient capacity and capability to maintain service quality whilst going through a process of reconfiguration	3322	QAC

BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee(s)
A304	There is a lack of community provision in place as an alternative to inpatient care		QAC
A401i	Insufficient understanding of Trust baseline costs and potential to deliver productivity and efficiency outcomes	2175	FIC
		3718	FIC
A401ii	Trust governance systems are not sufficiently embedded	3890	AC
A402	There is a lack of a public health-driven commissioning strategy		BoD
A403	Interdependencies of reconfiguration of community and inpatient restructure are not aligned with the estate plan and associated funding	2175	FIC
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

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O1 I	Executive Lead: Executive Director - Nursing, Prof, Care Standards	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance).		Residual Risk (with current controls):	3	2	6	Last Review:	11/01/2018
		Target Risk (after improved controls):	3	1	3	Next Review:	10/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
An Executive-led interim Care Standards & Quality Assurance Team (CS&QAT) is in place.	The director is part time and interim. The manager is part time and interim. The administrator post is an unfunded cost pressure.	Funding for director post only in budget (Apr 17). New Director of Quality appointed to commence 1/4/18			Moderate
Outcomes of CQC Well Led Inspection (2016) and Comprehensive Inspection (2017). Clinical Services are fully engaged to address Regulatory Breaches & 'Shoulds'. Bespoke Care Standard Peer Inspections (CSPIs) undertaken by the CS&QAT and Head of Mental Health Legislation (for evidence and quality assurance). Executive-led 'Task & Finish Oversight Group' ran from June to December 2017 to ensure progress and delivery of action plans.	Trust-wide 'Safe' domain rating = 'Requires Improvement' (RI). Two Clinical Services (Hospital) are rated RI: 1. Rehab Wards & CERT. 2. Crisis Services & Health-Based Place of Safety. CQC Unannounced Inspection of Adult Social Care Service Wainwright Crescent 12th Sept 17 November Report rated RI (safe & well led domains).	Executive-led 'Task & Finish Oversight Group' has been operating from June - December 2017. Final status report to be received at TMG & QAC in Jan '18 and Board in Feb '18. Action Plan to address RI at Wainwright Crescent in place and submitted to CQC. Oversight by Director & CS&QAT is in place.	CQC Comprehensive Inspection Nov 16 overall rating 'Good'. - Quarterly CQC Engagement meetings (Feb, May, Aug, 17). - Monthly CQC Relationship Meetings (July, Sept 17). Clover Group (General Practice) CQC Announced Inspection 25th Sept 17. Final Report received in December '17 = Rated Good in all five domains & population groups. Clover City Practice inspected in November		Moderate

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
			2017. December Report rated Good in all five domains & population groups.		
Head of Mental Health Legislation in post (Jan '17). Monthly Mental Health Act Committee (MHAC). Revised MHA governance structure. Identification, monitoring and reporting system in place for compliance with the MHA. MHA Audit Compliance Programme in place. MHA Annual Work Plan. Following the CQC's Appreciative Inquiry (AI) Report (June 2017) a joint Development & Improvement Plan has been agreed with Sheffield City Council & Sheffield Children's FT Planned CSPI of MHA of ward, team and directorate governance	CSPI of MHA of Ward, Team & Directorate Governance meetings has not yet taken place.	Monthly & Quarterly MHAC Meetings & Reports. MHA Audit Compliance Programme in place: Weekly Ward and monthly Community Outcomes of Compliance Audits. MHA revised governance structure proposal approved by EDG and QAC March 17.	CQC MHA Monitoring Visit Reports (Jul, Aug, Sept 17). - CQC Appreciative Inquiry (AI) Visit Report (Jun 17). - Internal Audit (360 Assure) MH Legislation Governance Review & MCA Audit, ToRs agreed (Aug 17).	Full delivery of the AI Improvement & Development Plan. Evidence of performance management of the MHA at Ward, Team & Directorate SMT level via routine recording at governance meetings.	Moderate

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
meetings.					
Mental Capacity Act: Head of Mental Health Legislation in post & taken on full responsibility for the MCA. Associate Director Patient Safety in post (formerly Service Director) continues to have an operational lead on MCA. MCA revised governance structure being put in place. MCA Audit Compliance Programme in development. Monthly MCA Steering Group. Quarterly MCA Practice Development Group. MCA Annual Work Plan.	Revised governance structure not fully in place. MCA Audit Compliance Programme yet to be delivered.	Monthly MCA Steering Group & Minutes Output from MCA Practice Development Group fed into MCA Steering Group. Delivery of MCA Annual Work Plan overseen by MCA Steering Group. Quarterly MCA Performance Report to EDG & QAC (from Q2 17/18). Monthly Mandatory Training Uptake Report.	Internal Audit Reports = limited assurance (Mar 16 & May 17). CQC Inspection (Report March 17).	Full governance and reporting system being put in place.	Moderate
CSPI: Trust currently has a small scale and limited arrangement for CSPIs and quality assurance.	An appropriately resourced CSPI and quality assurance function is required to enable services to be assessed against all CQC Key Lines of Enquiry (KLOE), work towards RCP Accreditation, learn from others and to achieve 'Outstanding'.	Current interim CS&QAT Team.	CQC Inspection overall rating 'Good' (Mar 17).	Limited capacity of the current CS&QAT	Moderate

Target Date: 31/05/2018 Responsible Person: Liz Lightbown

BOARD ASSURANCE FRAMEWORK 2017/18

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

Action Details	Action Progress
Recruit to a substantive Head of Care Standards and Quality Assurance post: to be reviewed by the new Director of Quality once established in post.	Director of Quality appointed to commence in post 1/4/18. Will review staffing requirements for Care Standards & Quality Assurance by May 2018.

Target Date: 30/03/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
MCA CSPIs to be undertaken.	

Target Date: 28/02/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
MHA CSPI's to be undertaken.	Due to workload and competing priorities this has been rescheduled to take place by end of February 2018.

Target Date: 30/04/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
Business case to Business Planning Group by April '18 for Care Standards Peer Inspection (CSPI) & Quality Assurance function.	Draft Business Case produced, reviewed by exec (LL) requires further work (++) and engagement with colleagues from PMO, finance & operations. Meetings scheduled Preference to involve new Director of Quality (1/4/18 start date)

Target Date: 31/03/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
Internal Audit (360 Assure) to review MH legislation's governance arrangements and aspects of the MCA.	Audit work by IA due for completion within the 17/18 IA schedule ---------- Terms of Reference for the Audit agreed September 2017.

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

	1st meeting took place early October 2017. Date of audit report completion not yet advised but potentially going to Jan 18 Audit Committee.

Target Date: 31/03/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
Actions from previous IA reports to be completed.	Update on IA actions re: MCA& DoLS received at EDG & QAC in November '17. All actions are complete with the exception of two which are partially met and in progress. 1) DoLS audits 2) Monitoring of DoLS

Target Date: 31/05/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
New Director of Quality to review admin requirements across the CS&QAT and the Clinical Governance functions .	

Target Date: 30/03/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
Identification, monitoring & reporting system being implemented for MCA.	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O1 II	Executive Lead: Executive Medical Director	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
Inability to provide assurance regarding improvement in the quality of patient care.		Residual Risk (with current controls):	3	2	6	Last Review:	09/01/2018
		Target Risk (after improved controls):	3	1	3	Next Review:	09/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Implementation of Quality Improvement and Assurance (QI&A) Strategy.	Strategy due for review.	Progress reports on QI&A strategy implementation to QAC (bi-annual). This includes updates on the impact of Microsystems. Quarterly Clinical Effectiveness Group assurance reports to QAC which include progress on quality improvement projects.	Annual Quality Report.		Moderate
Quality schedule in place as part of national contract with NHS Sheffield CCG.		Targets within the Quality Schedule are incorporated into relevant quarterly assurance reports to QAC. Quarterly Impact Assessment (QIA) assurance reports to QAC. All CIP QIAs considered by Clinical/Corporate panel and signed off by EDG.	Quality is monitored by NHS Sheffield CCG via quarterly Quality Performance Reviews. Any issues are escalated to the monthly Contract Monitoring Group and/or Contract Monitoring Board.		Moderate

Target Date: 30/04/2018 Responsible Person: Tania Baxter

BOARD ASSURANCE FRAMEWORK 2017/18

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

Action Details	Action Progress
QI&A Strategy to be refreshed following request by QAC in November 2017. Revised strategy to be taken to QAC.	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O2 I | Executive Lead: Executive Director - Nursing, Prof, Care Standards

Failure to deliver safe care due to insufficient numbers of appropriately trained staff.

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

BAF Risk Review Date:
Last Review: 06/02/2018
Next Review: 08/03/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Monthly Safer Staffing Group overseen by the Executive Director of Nursing (DoN) & chaired by the Deputy Chief Nurse. Monthly review & analysis of Safer Staffing data (& action) by DoN & Deputy Chief Nurse. Ward managers and senior nurses manage ward staffing levels on a daily basis. Senior nurse-led bed management and staff redeployment system in place.	Demand for Registered Nurse (RN) posts is greater than available supply = RN Vacancies No Monthly Vacancy Factor Report by Ward & Team. No up to date RN Workforce Profile. No RN Workforce Modelling & Delivery plan (including ACP & Apprenticeships Business Cases).	Monthly Safer Staffing Reports to EDG & BoD. Daily and weekly bed management and staff redeployment reports.	Internal Audit Report on Safer Staffing = 'Significant Assurance' (Feb 17). NHSI Retention Data Pack (Sept 17).		Moderate
A new E-Rostering System (Allocate) has been purchased and is operational. Allocate Health Roster Module is operational. Allocate Safe Care Module training delivered, being implemented & tested.	Not all RNs are competent using the Allocate E-rostering system. Inconsistent application of E-rostering rules across wards. Full functionality of the E-rostering system yet to be realised.	Monthly E-Rostering Group reports to Effective Staffing Group. Monthly Safer Staffing Group reports to EDG and BoD.	NHSI Good Rostering Guidance (Jul 16). NQB Safer Staffing Guidance (Jul 16).	Benchmarking NHSI Good Rostering Guidance to be completed.	Limited
Executive and Board lead for	No specific E-Rostering report to Board.	E-Rostering Group reports to			Limited

BOARD ASSURANCE FRAMEWORK 2017/18

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

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

Target Date:	28/02/2018	Responsible Person:	Liz Lightbown

Action Details	Action Progress
Detailed RN Workforce Delivery Plan required.	Deputy Chief Nurse returned full time to substantive post one month later than planned with effect from 8/1/18. Workforce data to be compiled for the RN workforce by 28/2/18

Target Date:	28/02/2018	Responsible Person:	Dean Wilson

Action Details	Action Progress
Benchmarking against the NHSI Good Rostering Guide to be completed with HR Lead.	Deputy Chief Nurse to review progress

Target Date:	14/02/2018	Responsible Person:	Dean Wilson

Action Details	Action Progress
HR Director to have full oversight, sign off and produce a report to Board on the progress and status of E-Rostering. E-Rostering group next reporting to Effective Staffing Group in December 2017. Following this a report will be produced for January 2018 Board.	Report delivered to extra ESG (1/2/18) that benchmarked the Trust against the NHSi Good Practice Guidance on Rostering. This gave assurance on key matters in hand and identified some areas for development. These to be taken forward via the Safer Staffing Group and monitored via the new Safer Staffing Reporting. One specific proposal 'Trust-wide review of headroom' to be presented by Guy Hollingsworth for discussion at the next ESG in March 2018. ESG will report to WODC, as per Trust Governance Structure and to Board via WODC. ---------- Effective staffing group met 12th December, verbal update delivered on purpose of E-Rostering steering group. Report to February 2018 Board. An extra-ordinary Effective Staffing Group is to be scheduled for January 2018 to provide additional assurance. Target date changed to take account of Board meeting dates.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Target Date: 30/03/2018 Responsible Person: Liz Lightbown

Action Details	Action Progress
A strategic trust-wide rolling recruitment programme commenced in July 2017. New Deputy Director of Nursing Operations & Associate Clinical Director in post from 1/1/18 & will work with Deputy Chief Nurse on a plan for addressing Nurse recruitment & retention, prioritising Acute & LD, followed by Community.	Vacancy Report for EDG (Jan'18) being completed for Acute Nursing by Deputy Chief Nurse. Application to a national RCN & HEE "Demonstrating the value of LD Nursing" Programme being completed by LD Nurse Consultant / Exec Sponsor LL by 15/1/18

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O2 II	Executive Lead: Executive Medical Director				BAF Risk Review Date:	
Inability to provide assurance regarding improvement in the safety of patient care.	Risk Rating:	Impact	Likelihood	Score	Last Review:	09/01/2018
	Residual Risk (with current controls):	4	2	8	Next Review:	09/02/2018
	Target Risk (after improved controls):	2	2	4		

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Patient Safety Improvement Plan developed and approved by BoD June 17.	Patient Safety Improvement Plan not yet fully implemented.	Progress of implementation plan reported to QAC quarterly.	CQC inspection report (March 17).	CQC rating of 'requires improvement' for patient safety.	Limited
Service User Safety Group monitors patient safety.		Quarterly assurance reports from Service User Safety Group to QAC. Learning from incidents reported to QAC on a quarterly basis. Quarterly mortality reports to QAC.	Bi-annual patient safety incident data from National Reporting Learning System (NRLS).		Significant

Target Date: 30/03/2018 Responsible Person: Mike Hunter

Action Details	Action Progress
Safety implementation plan in place and being monitored.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1.3 Provide Positive Experiences And Outcomes For Service Users

Risk Ref: A1O3 Executive Lead: Executive Medical Director Failure to comprehensively capture the experience of our service users and take appropriate action.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	2	6	Last Review: 09/01/2018
	Target Risk (after improved controls):	2	1	2	Next Review: 09/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Implementation of the 5-Year Service User Engagement Strategy.	Service User Engagement Strategy Implementation Plan not fully embedded.	Quarterly Service User Engagement Group assurance reports (including Friends and Family data) to QAC. Quarterly Complaints & Compliments report to QAC. Innovation & Inclusion Manager appointed to drive service user engagement implementation strategy. Paper presented to QAC in Oct 17 detailing next stage of strategy implementation.	Care Quality Commission inspection reports - March 17. Monthly national benchmarking data from FFT. Continuous Care Opinion feedback.	Improvements required in FFT and Care Opinion systems in order to adequately manage and learn from feedback.	Moderate
Service Users involved in Microsystem projects within teams.		Quarterly assurance reports from SUSEG to QAC.			Significant
Service User recruited within QI Team to strengthen engagement across the Trust.		Quarterly assurance reports from SUSEG to QAC.			Significant
Service user feedback mechanisms are in place, eg Friends and Family Test, Care Opinion, exit questionnaires.		Quarterly assurance reports from SUSEG to QAC.	Monthly national benchmarking data from NHS England on FFT. Continuous Care Opinion	Limited responses on both FFT and Care Opinion do not provide sufficient assurance on experience.	Limited

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1.3 Provide Positive Experiences And Outcomes For Service Users

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
			data.		

Target Date: 31/03/2018	Responsible Person: Tania Baxter
Action Details	Action Progress
Work with directorates to improve the utilisation of Care Opinion to capture feedback and learn from it.	

Target Date: 30/06/2018	Responsible Person: Tania Baxter
Action Details	Action Progress
Actively promote the use of FFT in areas of poor uptake and understand the issues surrounding this.	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O4 I Executive Lead: Executive Director - Operational Delivery Failure to achieve national performance targets for Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP) services.	Risk Rating:	Impact	Likelihood	Score
	Residual Risk (with current controls):	4	4	16
	Target Risk (after improved controls):	1	3	3

BAF Risk Review Date:
Last Review: 03/01/2018
Next Review: 02/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Monthly monitoring of national waiting times. Contract in place with Commissioners.		Clinical and corporate monthly performance report to FIC, QAC, EDG and BoD. Quarterly service reviews. Year end negotiation with Commissioners.	Reporting via Unify for EIP and IAPT. Monthly report to NHS England. Contract Management Group meets monthly and Board bi-monthly to review investment and performance.		Significant
Quality Standards within CCG contract.		Monthly performance reports to EDG/QAC/Board.	Monthly Quality Performance Review Group (CCG).		Significant
New EIP clinical structure agreed. As part of the CMHT reconfiguration additional posts have been identified and appointed to through the preferencing process.		CMHT reconfiguration updates to TOG.			Moderate
Negotiations with CCG resulted in successfully securing additional funds to address increased demand. £650k p/a recurrent.					Significant
Review of Trust's interpretation of EIP standards against a regional	Understand how benchmarking data influences planning in the organisation.	Benchmarking data reported to QAC.			Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
benchmark complete. Reports are now in line with other regional providers providing the Trust with effective and reliable benchmarking statistics.					

Target Date: 01/04/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
To explore building IAPT dashboard and clarify use of the same performance indicators that they currently used via the excel dashboards built by Paul Gears.	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A1O4 II	Executive Lead: Executive Director - Operational Delivery	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
A lack of ability to influence our Commissioner's intentions.		Residual Risk (with current controls):	4	2	8	Last Review:	03/01/2018
		Target Risk (after improved controls):	2	2	4	Next Review:	04/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Trust working with Commissioners on Transformation Agenda (led by LDS and MH Delivery Boards with key clinical individuals working into projects). Commissioning intentions agreed with CCG. Escalation procedures in place.		Fortnightly contract update report provided to Business Planning Group (as subgroup of EDG). Two-monthly reports to FIC on contract performance.	Contract Management Group (NHS SCCG & SCC) meet monthly and Board bi-monthly. Board to Board meetings with NHS SCCG and SYHA 13/9/17 to be followed up in six months. Quarterly review with NHS Improvement on contract performance. Contract monitoring with NHS England. Contract monitoring with SCC.	No underpinning contract in place with SCC.	Moderate
Joint Director of Strategic Commissioning post in place.					Significant
Governance arrangements for Transformation Agenda agreed. Development Board chaired by Kevan Taylor who also sits on the Executive.					Significant

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Identified CCG individual to lead on developing a city-wide dementia strategy.	City-wide dementia strategy to support the future of Trust services not yet in place.				Moderate

Target Date: 31/01/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
3 organisations including SHSC working together to identify a single efficiency total. The process is managed by SHSC across the whole of mental health, learning disability and continued health care (dementia) spend.	Target date amended to reflect the multiple governance sign-offs to 31 January 2018 ---------- Work continues through the merging Accountable Care Partnership to populate a proposed single, shared efficiency target for mental health & learning disabilities. The process for multiple governance sign off arrangements will be concluded by end of January 2018. In the interim, the Transformational Group continues to meet monthly to coordinate and steer the change programmes under its portfolio including liaison, dementia strategy, primary care mental health, nursing & residential care & IAPT LTC/MUS.

Target Date: 23/03/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
Transformation project addressing the lack of a city-wide dementia strategy.	Joint health and social care dementia strategy development still ongoing and likely to impact on services commissioned from SHSC. Implications as yet unclear. ---------- New CCG lead identified to take forward city-wide dementia strategy. This will feed into the mental health and learning disability delivery boards.

Target Date: 30/03/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
Contract Management Group meet with SCC and SCCG to develop and agree a new contract.	Currently working out details for 18/19 contract. Supply agreement ready to be signed subject to further negotiations on pension risk.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE	Strategic Objective: 2.1 We Will Manage Change Positively And Effectively Ensuring Support For Staff.

Risk Ref: A2O1 Executive Lead: Director Of Human Resources An inability to re-deploy staff as a result of organisational change.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	2	6	Last Review: 18/12/2017
	Target Risk (after improved controls):	2	2	4	Next Review: 17/01/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Redeployment Co-ordination Group established and redeployment process in place.	Terms of reference to be reviewed to take account of lessons learned	Redeployment Co-ordination Group reports to Vacancy Control Panel (VCP) - Monthly. VCP exception report contained within Workforce Report to WODC - Quarterly. Redeployment Policy reviewed 2017 and in place.			Significant

Target Date: 31/03/2018 Responsible Person: Sarah Bawden	
Action Details	Action Progress
● Review terms of Reference for the Redeployment Co-ordination Group	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A2O2 Executive Lead: Director Of Human Resources 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.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	4	2	8	Last Review: 06/02/2018
	Target Risk (after improved controls):	2	2	4	Next Review: 08/03/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Effective Staffing Group oversees Workforce Planning Group, Medical Staffing Group, Bank Staffing Group, Agency and Off Payroll Group, Safer Staffing Group, E-Rostering Group.		Quarterly Effective Staffing Group reports to WODC. Workforce In-Year monitoring return to NHS Improvement Monthly report to NHS Improvement on nursing agency/bank usage.	Contract monitoring report to NHS Sheffield CCG. Internal Audit Report on Safe Staffing gave 'significant assurance' (May 17).		Significant
Nurse recruitment retention group to review specific challenges for Nursing		Nurse Retention plan		Nurse retention plan in development to be completed February 2018	Moderate
Effective Staffing Group (ESG) operational from August 2017.		Quarterly ESG reports to WODC.		Terms of reference need review	Moderate
Health Education England annual workforce planning return.		Workforce Planning Group (monthly meeting)	Follow up meeting with all returning officers for moderation by Health Education England (annual).		Significant
Workforce Strategy approved by Board Sept 17. Workforce Strategy Delivery Plan in place and progress reported to WODC quarterly		Quarterly action plan progress reports to WODC from Oct 17.			Significant
Separate KPI appendix to the delivery plan agreed at WODC on		quarterly review at WODC			Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 2. PEOPLE

Strategic Objective: 2.2 We Will Develop A Strategic Approach To Enable Workforce Transformation

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
25/10/17.					

Target Date: 15/01/2018 Responsible Person: Dean Wilson

Action Details	Action Progress
Develop Nurse retention plan by February 2018	NHSI retention support visit 15/1/18

Action Details	Action Progress
Review terms of reference for Effective Staffing Group	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A2O3 Executive Lead: Director Of Human Resources

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

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

BAF Risk Review Date:
Last Review: 06/02/2018
Next Review: 08/03/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Review of and learning from employment tribunals.	Lack of systematic review and follow up following Employment Tribunals.	Disciplinary Policy audit completed 2017. Disciplinary Policy updated and in place. Systematic case review following completion of cases.			Moderate
Leadership programme agreed via EDG.	Progress made, but implementation required for a number of modules for the Leadership programme. Requires further investment to further support leadership work.	Progress of Leadership Programme included in workforce report to WODC and where appropriate to the Board.			Moderate
Good engagement with Schwarz Rounds.					Significant
PDR compliance.		Performance reports to WODC quarterly and Board monthly. Progression criteria includes PDR compliance.	Benchmarking information from the staff survey (annually).		Significant
Coaching Service established.	.	Reports to WODC on a quarterly basis.			Moderate
Microsystems developed and involved in projects.		Quarterly reports to QAC.			Significant
Values-based recruitment in operation.		Recruitment policy		Recruitment Policy under review	Significant

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Annual Staff Survey, Friends and Family Test operational.		Progress reports on Staff Survey Action Plan to WODC (quarterly).	Friends and Family Test (FFT). Monthly contract management meeting with CCG (CQUIN).		Significant
Workplace Wellbeing Service.		Exception reports to HR SMT and WODC bi-annually. Associated CQUIN for Workplace Wellbeing. Progress against CQUIN reported to WODC quarterly.	Monthly contract management meeting with NHS Sheffield CCG.		Significant
People Plans for all areas in place and reviewed annually		People Plan reviewed by WODC on a quarterly basis	Planned Internal Audit report on Workforce Planning due March 2018 to provide a level of assurance		Moderate

Target Date: 28/02/2018	Responsible Person: Dean Wilson
Action Details	Action Progress
Roll out of leadership programme under development.	Investment case made as part of business planning

Target Date: 29/03/2018	Responsible Person: Dean Wilson
Action Details	Action Progress
Introduce systematic process for learning from Employment Tribunals.	Learning for those directly involved in Specific Cases to inform action plan and leaning briefings to be cascaded across TRUST management.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A2O4 Executive Lead: Director Of Human Resources Risk of low motivation and morale compromises staff motivation.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	3	9	Last Review: 03/01/2018
	Target Risk (after improved controls):	2	2	4	Next Review: 02/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Underpinning governance providing support for staff.		Numerous support and engagement groups in place including Health & Wellbeing Group, Workplace Wellbeing, IAPT. Progress against Staff Survey action plan reported quarterly to WODC.			Significant
A CQUIN for health and wellbeing in place.		Progress against CQUIN reported to WODC quarterly. Health and Wellbeing group bi-monthly review of progress against actions to achieve CQUINS funding.	Monthly contract management meeting with CCG.		Significant
Physio Med service in place for Muscular Skeletal issues.		Quarterly Report from Physio MED report to Director of HR, reported to WODC quarterly (as of Jan 2018, 143 staff members through the service)			Significant
Communications Strategy developed.	Communications strategy awaiting final approval.	Clarity of communication and consistency of Trust messages via a number of			Moderate

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
		mechanisms including Chief Executive letter, directorate communication structure, communication digest etc.			
Proactive sessions provided by Workplace Wellbeing (WWB) for staff/teams undergoing organisational change.		WWB report to WODC (quarterly) identifying issues so that support can be provided where needed. WWB link bi monthly to Redeployment Co-ordination Group (RCG)to ensure information sharing			Significant
Psychological Service (in house WWB and IAPT) for staff operational from 25/10/17.		Report to Director of HR reporting numbers of cases and areas of concern from WWB on a quarterly basis.			Full Assurance
Active promotion of Wellbeing services through staff support WIDGET on the intranet and other Trust-wide literature		Analysing intranet traffic of staff support WIDGET by Staff Health & Wellbeing Group (ad-hoc). Quarterly reporting to WODC and The Health and Wellbeing Group. Info regarding WIDGET included in staff induction.			Significant
Occupational Health Service providing medical advice and		Annual report on usage provided by Occupational			Significant

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
support to staff and managers and pre employment health screening		Health Service to Director of HR			

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic Objective: 3.1 Deliver Interventions And Support Closer To General Practice, Neighbourhoods And Embedded Within Our Services

Risk Ref: A3O1 Executive Lead: Executive Director - Operational Delivery Lack of Primary Care Strategy.	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:
	Residual Risk (with current controls):	3	3	9	Last Review: 18/01/2018
	Target Risk (after improved controls):	2	2	4	Next Review: 17/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
EDG met (June 17) to begin the process of developing a primary care strategy. Strategy developed through EDG and BoD Development sessions in July and August 2017.	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.	Alignment to CCG & PCS Primary Care Strategy (Board Development Session Aug 2017).			Moderate

Target Date: 14/02/2018 Responsible Person: Phillip Easthope	
Action Details	Action Progress
● Draft strategy to Board.	Draft strategy reviewed at EDG, BoD needs rescheduling following changes to planned development session, to be confirmed. ---------- Draft strategy to EDG on 18th January and Feb Board

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A3O2 Executive Lead: Executive Director - Operational Delivery

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

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

BAF Risk Review Date:
Last Review: 05/01/2018
Next Review: 07/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
	No partnership engagement framework in place.	Individual reports to EDG Strategy sessions and TMG regarding service development opportunities (as and when).			Limited

Target Date: 31/01/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
Procurement team reviewing value of trust Voluntary Community and Social Enterprise (VCSE) expenditure contracts January 2018.	
EDG to review and agree requirements for partnership engagement framework for decisions about local partnerships (e.g. with VCSE and Accountable Care System Partners).	
EDG to review and agree broader requirements for partnership engagement beyond Accountable Care System (supply chain, digital fast followers) for BOD approval.	There are ' new' potential national partners (Worcs or Birmingham in the frame for Digital Fast Followers) which the local/ ACS discussions will not cover - so decisions are still being made pragmatically on an emergent basis.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A3O3 Executive Lead: Executive Director - Operational Delivery

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

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

BAF Risk Review Date:
Last Review: 04/01/2018
Next Review: 03/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Clear Community Mental Health Team reconfiguration implementation plan in place with agreed timescales.	Staffing issues i.e. temporary posts/sickness/vacancies which can undermine quality during the transitional period.	Monthly reconfiguration update to EDG. Mobilisation updates to EDG. Safety dashboard to QAC/BoD and full performance report to EDG (monthly). Quality Impact Assessments being undertaken to monitor change. Regular meetings with staff. Co-creation of care pathways for staff and service users. Transition plan in place.	Monthly contract meeting with NHS SCCG.		Significant

Target Date: 31/01/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
Agreed action plan in place and being implemented.	Staff gradually moving into new posts. Temporary staffing solutions in place e.g. agency cover and temporary staff transfers from other areas. Implementation is being delivered to timescale.

AIM: 3. FUTURE SERVICES	Strategic Objective: 3.3 Provide Effective Community Care And Treatment
	---------- Mobilisation plan in place. Preferencing taken place with 86% of staff securing 1st choice, 10% securing their second and 4% their 3rd choice. Anticipated all will bein post by end January 2018.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 3. FUTURE SERVICES	Strategic Objective: 3.4 Provision Of High Quality Inpatient Services Supported By Effective Alternatives

Risk Ref: A3O4 Executive Lead: Executive Director - Operational Delivery

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

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	3	9
Target Risk (after improved controls):	2	3	6

BAF Risk Review Date:
Last Review: 04/01/2018
Next Review: 03/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
A review of step-up beds has been completed and has informed a new specification.		Report on Crisis House to FIC, BPG and EDG October 2017.	Monthly contracting meeting NHS SCCG.		Significant
Tender specification for the Crisis House completed and tender process began October 2017.					Significant

Target Date: 01/04/2018 Responsible Person: Clive Clarke

Action Details	Action Progress
● Developing a tender specification for the Crisis House. Tender process to begin in October 2017 with service commencing April 2018.	Interviews for new Crisis House tender are taking place in January 2018 and a decision on the successful provider will be made by 21 January 2018. ---------- Tender specification completed and notice of interest published. On target for new service to commence 1/4/18.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A4O1 I Executive Lead: Executive Director Of Finance

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

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	2	8
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:
Last Review: 10/01/2018
Next Review: 09/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Strong financial management.		Monthly finance report to Board.	Internal Audit report providing significant assurance on financial management (June 17). NHSI quarterly monitoring review letter. Head of Internal Audit Opinion. Year End Report to those responsible for governance. Annual Governance Statement. Corporate Governance Statement.		Significant
Financial Plan including CIP	Lack of understanding of productivity across all services.	CIP and Disinvestment reporting (TOG, FIC & EDG).			Significant
Governance and reporting arrangements in place.	Weaknesses in financial governance at directorate level. Lack of consistency of directorate financial management.	Monthly finance report to Board, EDG, FIC, TOG & BPG.			Significant

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY

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

Target Date: 31/03/2018	Responsible Person: Phillip Easthope
Action Details	Action Progress
Standardisation of financial governance through clinical directorate restructure.	Clinical Directorate structure on-going, management structure handovers commencing

Target Date: 30/03/2018	Responsible Person: Phillip Easthope
Action Details	Action Progress
Productivity KPI and/or benchmark on cost for all clinical and corporate services.	NHS benchmarking data club data on clinical services received. Corporate data outstanding. NHS Improvement has requested data for corporate services which is due to be submitted November 2017. Anticipate having reliable data to inform 18/19 planning round.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A4O1 II	Executive Lead: Chief Executive	Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:	
Trust governance systems are not sufficiently embedded.		Residual Risk (with current controls):	3	4	12	Last Review:	07/02/2018
		Target Risk (after improved controls):	3	2	6	Next Review:	10/03/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Established board committees providing assurance to the Board.	Lack of clarity of assurance responsibilities within terms of reference for each board committee. Appropriate challenge and performance management of information at operational group level prior to presentation to Board Committees.	Minutes of committees. Annual Report. Existing terms of reference and work programmes currently in place. Significant issues report to board from each committee.	Annual Head of Audit Opinion. CQC Well-Led and comprehensive review (2-yearly). Internal audit reports. Quarterly NHS Improvement Review Meetings.	Head of Audit Opinion for 16/17 'moderate'. Embedding of assurance systems and processes.	Moderate
Risk Management Strategy 2017 in place.		Approval by Audit Committee October and Board November 2017. Annual Governance Statement. Corporate Governance Statement.		360 Internal Audit of Operational Risk Management (Jan 18) - limited assurance	Limited
Policy system management in place.	Policy System Management process insufficiently embedded in the organisation.	Policy Governance Group reports to EDG and CQC Task and Finish Group.	Internal Audit 360 Assurance report Sept 17	Limited assurance provided by Internal Audit 360 Assurance Report	Limited
Meeting statutory requirements of commissioners and regulators.		Provider licence self-certification. Annual governance	Quarterly meetings with NHS Improvement. Planned annual review		Significant

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
		statement. Corporate governance statement. Quarterly returns to NHS Improvement. Contract Management Board. Board to Board meetings with commissioners.	meeting between NHS Improvement and Board.		

Target Date: 30/03/2018 Responsible Person: Margaret Saunders

Action Details	Action Progress
Committee Terms of Reference are being reviewed for consistency and clarity.	QAC ToR approved 27/11/17. All committee ToRs presented on 23/1/18 at Audit Committee. Subject to minor amendments, AC approved AC ToRs. WODC ToR presented to WODC on 30/1/18. Significant changes required. To be represented to WODC in 24/4/18. FIC ToR to be presented on 26/3/18. ---------- All Board Committee Terms of Reference (ToRs) have been reviewed and aligned and being presented to Audit Committee 23 January 2018.

Target Date: 30/03/2018 Responsible Person: Margaret Saunders

Action Details	Action Progress
Action plan prepared with recommendations from 360 Assure Trust Committee Governance consultancy review follow up.	3 of 7 actions completed. Outstanding actions progressing.

Target Date: 30/06/2018 Responsible Person: Margaret Saunders

BOARD ASSURANCE FRAMEWORK 2017/18

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

Action Details	Action Progress
Process commenced to review and align all Terms of Reference (ToRs) and Work Programmes of Operational Groups providing Assurance to Board Committees. Commenced with the Quality Assurance Committee (QAC), Finance & Investment Committee (FIC) and Workforce & Organisational Development Committee (WODC) to follow.	QAC completed and presented to committee on 22/1/18. Work progressing for other Board committees.

Action Details	Action Progress
Following publication of 360 Assure IA report of Operational Risk Management, risk included on Corporate Risk Register 1/2/18, and action plan developed between Corporate and Clinical Governance departments.	

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY

Strategic Objective: 4.2 We Will Adapt Some Of The Services We Provide In Response To Demand And Market Conditions

Risk Ref: A4O2 Executive Lead: Executive Director - Operational Delivery

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

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	3	9
Target Risk (after improved controls):	2	3	6

BAF Risk Review Date:
Last Review: 18/01/2018
Next Review: 17/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Performance data provides clear indications of needs/trends/gaps that enable forward thinking and influencing of partners.	No systems currently in place to ensure that performance data/intelligence is fed into relevant delivery boards.				Moderate
Implementation of 5 Year Forward View. Additional recurrent funding secured for EIP and Liaison Psychiatry.		Report of implementation of 5 Year Forward View to EDG and Board (Jun 17). Transformational Operational Group (TOG) reports on service development plans based on 5 year forward view.			Moderate
New governance structure agreed for Delivery Board which facilitates Trust's ability to influence the transformation agenda. Chaired by Kevan Taylor.					Moderate

Target Date: 30/03/2018 Responsible Person: Phillip Easthope

Action Details	Action Progress
● Development of QlikView to capture realtime data. This is a presentational tool showing data which can be analysed.	The clinical dashboards are being merged to create a single clinical dashboard. The community elements are being developed post restructure and incorporated into the clinical dashboard Whilst the CHMT & clinical directorate restructure provide significant challenges with maintaining existing reporting capabilities and accuracy, it also provides the trust & services focus and priority needed to work towards a common analysis, dashboard and supporting KPI's.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic Objective: 4.2 We Will Adapt Some Of The Services We Provide In Response To Demand And Market Conditions
	Qlik is still the strategic tool of choice for the trust, as we continue to build further automation, data feeds, data warehouse and self-service reporting capability. 2018 reporting roadmap to include next 6mths delivery path. ---------- Seven dashboards now operational (incidents, acute inpatients, specialist, HR, Clustering, EIP, user's audit) Executive dashboard requires completion. Additional dashboards can be developed subject to the engagement of services. Effectiveness of QlikView tested through the user's audit which will show how dashboards are being used.

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A4O3 Executive Lead: Executive Director Of Finance Interdependencies of reconfiguration of community and inpatient service restructure are not aligned with the Estate Plan and associated funding.	Risk Rating:	Impact	Likelihood	Score
	Residual Risk (with current controls):	4	3	12
	Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:
Last Review: 11/12/2017
Next Review: 10/01/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Approved Estates Strategy	Strategy Implementation Plans not fully developed - gaps around estate utilisation and maximisation. Estates related funding requirements for community restructure not yet clear and will link to disposal and acquisition of properties.	Estates Strategy update to Business Planning Group Dec 17.	External monthly project management (Arcadis) reports to Capital Board monthly re Acute Care Reconfiguration Phase 2.	Full development of implementation plans. Capacity and capability to deliver estate strategy. Estimated and tendered costs for estates solutions for community reconfiguration. Overall financial appraisal (capital and revenue).	Moderate
Governance and reporting arrangements in place through EDG via TOG/BPG.	TOG reporting/governance processes not fully embedded.	TOG minutes (monthly) and Checkpoint Reports and Status Reports.			Moderate
Capital Board oversight.	Capital funding requirements for Acute Care Reconfiguration Phase 2 and wider five year capital funding requirements are best estimates only. For all significant capital expenditure plans, the potential impact on capital and revenue budgets is not yet fully understood.	Capital Board minutes (monthly). Routine governance reports through TOG, BPG, Capital Board and FIC.		Fully developed five year capital plans. Completed outline business case for Acute Care Reconfiguration Phase 2. Completed outline business case for Leaving	Moderate

BOARD ASSURANCE FRAMEWORK 2017/18

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

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
				Fulwood Project.	
Only Board can approve sale of assets.					Full Assurance
Stakeholder meetings held with all relevant community and inpatient service managers. Outcomes have informed the development of the plan to deliver the estates strategy.				Engagement is ongoing and plans being developed (for medium-term and long-term), but not yet finalised.	Moderate

Target Date: 29/03/2018 Responsible Person: Helen Payne

Action Details	Action Progress
Implementation plan updates as part of establishing routine reporting to TOG and BPG, EDG and FIC as required.	Update received by BPG in December 2017. Action expanded to reflect wider reporting and assurance requirements. Therefore target date extended to reflect this. ---------- Estates Strategy Implementation update going to TOG Nov 17 meeting, BPG Dec 17 meeting.

Target Date: 31/01/2018 Responsible Person: Helen Payne

Action Details	Action Progress
Plan for community restructure estates solutions will inform funding requirements (and disposals/acquisitions) via a business case. This will inform overall capital and revenue impacts.	Short-term solution (Netherthorpe House) business case was approved Nov 2017 and work will complete early 2018. Target date extended by 1 month to end January 2018.

Target Date: 28/02/2018 Responsible Person: James Sabin

Action Details	Action Progress
Outline business cases to be approved and preferred option selected. Construction tendering informs actual capital funding requirement for ACR Phase 2. This will inform overall capital and revenue impacts.	Potential delay in target date due to delays in the completion of the outline business case and queries from EDG on compliance required for do minimum option.

BOARD ASSURANCE FRAMEWORK 2017/18

AIM: 4. VALUE FOR MONEY	Strategic Objective: 4.3 An Estate Plan That Meets Our Needs
Outline business case for Leaving Fulwood to inform revenue and capital implications of wider capital strategy.	

BOARD ASSURANCE FRAMEWORK 2017/18

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

Risk Ref: A4O4	Executive Lead: Executive Director Of Finance			
There is a lack of embeddedness of digital strategy and interdependencies with associated strategies.	Risk Rating:	Impact	Likelihood	Score
	Residual Risk (with current controls):	3	4	12
	Target Risk (after improved controls):	2	4	8

BAF Risk Review Date:
Last Review: 08/01/2018
Next Review: 09/02/2018

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	Gaps in Control	Internal Assurance	External Assurance	Gaps in Assurance	
Compliance with IT Strategy (dynamic).		Data and Information Governance Board (DIGB) Business Planning Group (BPG).	Auditors (specific audits) and NHS England Digital Maturity Toolkit.	External assurance on IT Strategy.	Significant
Digital Transformation and Business Planning governance frameworks and mechanisms.	Embedding new mechanisms and develop implementation plans when required.				Significant

Target Date: 28/02/2018 Responsible Person: Nicola Haywood-Alexander

Action Details	Action Progress
Improve engagement with Digital Transformation Strategy.	Updated Strategy supported by EDG. BoD approval required and engagement plan to be developed