Board of Directors' Meeting Report – 2 May 2017
Agenda item 51/17

Title	Board Assurance Framework – 6 monthly review
Sponsoring Director	Yvonne Blucher, Managing Director
Author(s)	Brinda Sittapah, Company Secretary
Purpose	To provide a 6 monthly review of the Board Assurance Framework to the Board

Executive Summary

The Board Assurance Framework (BAF) has been reviewed over the course of the last few months to improve consistency with the application of the BAF methodology.

The BAF is reviewed on a monthly basis at the Corporate Governance Group which comprises of the members of the Site Leadership Team. The various Board Sub-Committees also review the BAF risks allocated to them by the Board at all their meetings.

BAF Risks 1, 2 & 6 were reviewed by the Quality Assurance Committee on 19 April and recommendations made by the Committee were incorporated in this report.

BAF Risk 3 was reviewed by the Audit Committee on 22 February and will be reviewed on 3 May.

BAF Risk 4&5 were reviewed by the Finance and Resources Committee on 26 April.

Date Reviewed by the Site Leadership Team	21 April 2017
Related Trust Objective	Excellent Patient Outcomes Excellent Patient Experience Engaged and Valued Staff Financial and Operational Sustainability – Financial, Operational, Estate
Related Risk	Risk 1 – Failure to provide adequate patient safety and quality of care Risk 2 – Poor patient experience Risk 3 – Failure to meet operational performance targets Risk 4 – Trust not being financially sustainable Risk 5 – Inability to recruit and retain staff Risk 6 – Unable to maintain estates and facilities to an adequate standard
Legal implications / regulatory requirements	The Board Assurance Framework is an important part of the Trust's internal control framework.
Quality impact assessment	There are no quality implications arising directly from this report.
Equality impact assessment	As far as can be ascertained this paper has no detrimental impact for the 9 protected characteristics under the Equality Act 2010.

Recommendations: The Board is asked to review the BAF risks and receive assurance from the report.

Risk 1	*Failure to provide adequate patient safety and quality of care*			**Director lead:** Director of Nursing and Medical Director	
	Link to Corporate Risk Register	**CQC Domain**	**Trust Strategic Objective:**	**Date last updated:**	20th April 2017
	Staffing: 2159, 2365, , 2623, 2500, 70, 2634 *Capacity: 2116, 2581, 2633, 2159, 2756, 2147, 1858, 2656, 2617* *Assessment: 2461, 2691*	**Safe** **Effective** **Caring** **Responsive** **Well-led**	**Excellent patient outcomes** **Excellent patient experience**	**Reviewed by Corporate Governance Group**	13th April 2017
				Reviewed by Quality Assurance Committee	19th April 2017
				Reviewed by Board	8th December 2016

Risk Rating	Likelihood	Consequence	Total
Initial	**4**	**5**	**20**
Current	**4**	**5**	**20**
Target	**3**	**5**	**15**

Impact:

Breach of licencing conditions

Regulatory action

Poorer patient outcomes

Adverse publicity/reputational damage

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc. Relevant actions in brackets)*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
Key policies and procedures in place on the intranet. e.g. WHO checklist; medicines management policies etc.	National and local Clinical Audit data; Quality and compliance audits (e.g. medicines management, IPC) Evidence of CQC compliance and progress with actions	Recurrent serious incidents
Key patient safety targets achieved (e.g. A&E 4 hour target)	Daily reports showing performance against 4 hour target, regularly reported as part of integrated performance review. (4)	Patient safety incidents
Safeguarding policies and procedures	Safeguarding minutes and quarterly report	Safeguarding concerns substantiated against the Trust raised
Quality Strategy	Quality indicators / dashboards	Not reported failing indicators
Mortality / morbidity review process	CRAB report	Increase in the SHMI

STAM training and staff induction in place (1)	Workforce data and STAM KPI's reported through IPR, and via Clinical Directorate compliance report to CGC	Reduction in compliance with STAM training
Infection prevention and control policies and processes	Infection and prevention and control compliance audits reported to CGC / QAC	Increase incidence in HAI
Patient safety processes (e.g. investigation and implementation of action following incident, SI, complaints)	Monthly SI report to board; report on numbers and actions relating to SIs, complaints, incidents, claims and inquests reported to QAC RCA / comprehensive investigation into all SIs and HCAIs.	Re-occurrence of Incidents and lessons have been learnt
Quality improvement programmes	Patient experience data (F&F, national and local surveys)	Increase in negative themes of the same themes
Clinical directorate performance management framework and process	Clinical Directorate performance management reports and actions taken	Failure to improve or maintain trajectories or targets
Quality impact assessments (5)	Robust governance process of QIAs	Negative impact on quality safety and patient experience Changes to service without undertaking the QIA process
Nurse Staffing establishment and skill mix reviews	Bi-monthly staffing establishment report to the board triangulating quality, safety and patient experience outcomes with staffing levels Daily use of safer nursing care tool to achieve safe staffing levels based on acuity and dependency	Low level of incidents attributed to poor staffing levels
Escalation processes for nurse staffing deficit, incorporating NICE guidelines	Staffing establishment report to board identifies red flags, mitigating actions and quality and safety outcomes	Low level of incidents attributed to poor staffing levels Increase in red flags
Committee structure in place – ToR's evidence areas to monitor to provide assurance	Committee minutes and work-plans evidence issues raised and actions taken	Risks and concerns are not raised at the relevant committee
Recruitment and retention strategy in place (2, 3)	Staffing reports to Trust Board and CCG	Failure to achieve trajectory and vacancy factor increases
Cancer Steering Group and action plan in place to address areas of underperformance.	Minutes showing action plan being reviewed	Failure to achieve access and treatment targets
New electronic patient observation system with central monitoring	Compliance reports	Increase in incidents were we failed to recognise a deteriorating patient
ePrescribing in place	Medication incident reports VTE compliance reports	Re-occurrence of medication incidents Increase of hospital acquired VTE
Medical workforce (junior and consultant) reviews underway	Rotas in place and reviewed daily. Medical handover daily to support decision making. Recruitment trajectory in place	Gaps in rotas - Rota co-ordinator issues daily updates where cover not identified Failure to achieve recruitment targets

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	**Action plan and date for completion of action:** *Specific actions with dates to address the gaps in controls or assurance*	**Date Due**
1. STAM training compliance not on target	Review of STAM training is currently underway. Mar 17 - Action tracker now in place to address gaps. Overall compliance as at 15th Feb was 82% (including bank staff) and 85% (excluding bank staff). Actions in place to address compliance for bank staff	Oct 2016
Poor staff levels: difficult to recruit to key posts including consultants, nursing, ODP; diagnostic radiography staff	Strategy in place to improve workforce planning, targeted recruitment plans and campaigns including international recruitment. Currently the trajectory for this is delayed due overseas recruitment delay in IELTS – currently the first cohort will arrive in June 2017. Mar 17 – recent nurse recruitment day was successful. A number of doctors posts are out to offer	December 2017
	Plan to achieve predicted trajectories – as above	December 2017
2. Concerns raised by Drs in training during School of Medicine and HEEoE visits, which could impact on morale of junior doctors, patient safety and the ability to recruit to medical vacancies. Potential loss of trainees to cover rotas	Revisit by HEEoE took place on 16th December. Meeting held following visit to address concerns raised and comprehensive action plan in place which is reviewed on a regular basis. Actions taken to provide additional support to reduce pressure on junior doctors' rota. Mar 17 - Actions on target. Buddy ward system implemented to provide additional support for medical outliers. Hospital out of hours (HOOH) project being implemented (due April 17)	April 2017
3. Failure to achieve the A&E 4-hour standard (significant increase in A&E attendances)	Daily monitoring of A&E 4-hour standard in place and impact of new medical model is being monitored. An Emergency Care Improvement plan is in place. External review of reasons for significant increase in A&E attendances is in progress. Staffing levels reviewed to match attendances. Update Sept 2016 - OPAT in place. Update Dec 2016 Red and Green days implementation stage 1 – 2 wards December 2016 and stage 2 all wards January 2017. Mar 17 – red to green rolled out, dashboard developed to review metrics and data completion is improving. Reconfiguration of BAMS and ambulatory care has taken place and further plans to implement clinical decisions unit to reduce admissions.	August 2017
4. Assurance that Quality Impact Assessments are effective	A report into the process and effectiveness of QIAs due to QAC in August 2016, action plan to follow this Update September 2016 following governance process review plan in place that this will now be reported to Clinical Governance Committee in October 2016 – Assurance meeting in place for December 2016 with CCG and assurance presentation to QAC December 2016	Sep 2016 Completed December 2016
5. Gaps in medical workforce	Rotas are reviewed daily, gaps identified and mitigation taken Rotas being reviewed to ensure adequate cover Recruitment plans in place and monitored / reviewed Plans to increase ambulatory and assessment beds to reduce outliers resulting in more manageable workload. Mar 17 – reconfiguration of BAMS completed and buddy ward system rolled out to provide increased support.	April 2017

Risk 2	*Poor patient experience (linked to poor patient outcomes as per Risk 1)*			**Director lead:** Director of Nursing and Medical Director	
	Link to Corporate Risk Register	***CQC Domain***	**Trust Strategic Objective:**	**Date last updated:**	20th April 2017
	Staffing: 70, 2030, 2147, 2365, 2453, 2461, 2500, 2623, 2634 *Capacity: 2116, 2581, 2633, 2159, 2656, 2474* *Assessment: 2691*	***Safe*** ***Effective*** ***Caring*** ***Responsive*** ***Well-led***	**Excellent patient outcomes** **Excellent patient experience** **Engaged and valued staff** **Financial and Operational Sustainability**	**Reviewed by Corporate Governance Group**	13 April 2017
				Reviewed by Quality Assurance Committee	19th April 2017
				Reviewed by Board	8th December 2016

Risk Rating	Likelihood	Consequence	Total
Initial	**4**	**5**	**20**
Current	**3**	**5**	**15**
Target	**3**	**4**	**12**

Target

25
20
15
10
5
0

Jul-15, Oct-15, Apr-16, May-16, Jul-16, Aug-16, Sep-16, Dec-16, Jan-17, Mar-17

Impact:

Breach of licencing conditions

Regulatory action

Poorer patient outcomes

Adverse publicity/reputational damage

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc).*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
Processes in place to analyse and collate patient experience data (Friends & Family Test; patient satisfaction surveys, comment cards, PALS)	Patient feedback (Friends and Family Test data, national patient survey data, CQC reports)	Recurrent negative feedback on recurrent themes Decrease in patient satisfaction Reduction in compliance with patient surveys
	Patient experience reported through Clinical Directorates performance meetings and to CGC	
	Patient experience reported to Quality assurance committee	
	Clinical audits and local patient surveys	
	Complaints Annual Report identifying learning from complaints, PALS and litigation	

Clinical Directorates patient experience surveys, Incident reporting, SI and complaint process promotes open culture of incident reporting	High levels of reporting and compliance with duty of candour.	Non-compliance with duty of candour
Procedures, policies and SOPs	Audit process in place to address compliance issues	Policies out of date Incidents relating non-compliance of polices
Staff training	Trajectory for STAM training reported through Performance meetings	Reduction in compliance with STAM training
Appraisal process	Medical revalidation programme	Lapses in registration
	Nurse revalidation	
Compliance with CQC Standards	CQC compliance report	Inadequate outcome from CQC Inspection
Discharge process in place	Audit in place for compliance	Increase in complaints / incidents relating to discharge
Risk assessment undertaken prior to opening escalation beds	Identification of 'Red Flag' staffing Auditing of risk assessment process	Beds being opened without risk assessment being undertaken Increase of Incidents Decrease staff satisfaction survey

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	**Action plan and date for completion of action:** *Specific actions with dates to address the gaps in controls or assurance*	**Date Due**
1. Communication issues about patient moves, patient flow, discharge process	Major project being launched to encompass internal transfers and discharges – Update September 2016 OPAT Launched 01/9/2016	~~Aug 2016~~
	Risk assessments introduced to assess the suitability of individual patients and ward environment prior to internal transfers, audits in place to assure compliance with the process - Completed	~~Dec 2016~~
	Employment of additional pharmacists to improve the discharge medication process – Completed	~~Jun 2016~~
	Patient focus group held regarding discharge – improvement ideas generated and fed into red and green days project and pharmacy improvements - Completed	~~September 2016~~
	Implementation of Red and Green days (December – 2 wards and full implementation January 2017). Mar 17 – dashboard in place to review metrics. Daily delay reasons and metrics to be presented at S@S to focus on system and process issues	~~January 2017~~ April 2017
	Bespoke feedback survey currently being undertaken in BAMS – feedback obtained and no additional issues highlighted - completed	January 2017
	Review of transfer SOP and risk assessment document – risk assessment document implemented and audit shows good compliance. SOP still to be written. Mar 17 – SOP now in place - completed	December 2016

<table>
<tr><td></td><td>Await results of national patient survey to determine patient experience with discharge process and communication and further actions to be developed accordingly</td><td>May 2017</td></tr>
<tr><td rowspan="3">2. Nursing revalidation implemented in April 2016, not all nursing staff will have revalidated until March 2019</td><td>Nurse revalidation co-ordinator in place – Completed</td><td>~~Aug 2016~~</td></tr>
<tr><td>Completion of first round of revalidation - Completed</td><td>~~Mar 2019~~</td></tr>
<tr><td>continue monitoring of compliance with revalidation</td><td>March 2019</td></tr>
<tr><td rowspan="3">3. Backlog in responding to patient complaints</td><td>New complaints process introduced April 2016 is being embedded in the Directorates – Completed</td><td>~~Aug 2016~~</td></tr>
<tr><td>Temporary staff in place – completed</td><td>~~October 2016~~</td></tr>
<tr><td>Trajectory of backlog in place - complaints backlog is reducing and meeting trajectory for achievement by March 2017. Mar 17 – as at 20th Mar, <100 complaints in backlog. KPIs being reviewed</td><td>March 2017</td></tr>
</table>

Risk 3	Failure to meet performance targets			Director lead: Director of Operations	
	Link to Corporate Risk Register	***CQC Domain***	**Trust Strategic Objective:**	**Date last updated:**	26 April 2017
	1864, 2152, 1853	***Safe*** ***Effective*** ***Caring*** ***Responsive*** ***Well-led***	**Excellent patient outcomes** **Excellent patient experience** **Financial and Operational Sustainability**	**Reviewed by Corporate Governance Group**	13 April 2017
				Reviewed by Audit Committee	22 February 2017
				Reviewed by Board	8 December 2016

Risk Rating	Likelihood	Consequence	Total
Initial	**5**	**5**	**25**
Current	**5**	**5**	**25**
Target	**3**	**4**	**12**

Impact:

- Poor patient experience
- Reputational damage
- Regulatory action

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc.)*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
STRATEGIC CONTROLS; Comprehensive action plan for each of the 3 key performance indicators: RTT, A&E & Cancer	Live dashboard that provides up to date information for the 3 key standards	Out of date information
	A and E performance reviewed at 'Safe at Southend' every morning, led by a member of the Senior Site Leadership/Executive team, including additional mitigations for the day as required. It is also reviewed throughout the day at each bed meeting, with action taken accordingly. Constant oversight and predictive actions are taken to prevent breaches via the control room team, where clinically possible.	Out of date information and key staff not knowing the Trust position

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc.)*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
	Dedicated teams monitoring and managing the patient pathways as part of Cancer and the RTT process, with clear escalation protocols in place for both RTT and Cancer targets.	Serious Untoward Incidents as a result of delays in treatment.
Inter-professional standards introduced 1st August 2016 to support change in culture and behaviour to refocus on patient flow and avoidance of delays in A and E. These replaced the '10 steps'.	A and E Breach delay reports and incident reports will demonstrate if non-compliance of the inter-professional standards occurs. Consultants will be held to account for delivery against these standards.	The Site Team/Deputy COO and COO will not receive escalations whereby consultants are not accepting referrals from A and E.
Access Board chaired by the CCG to review progress against the action plan and performance against the RTT & Cancer targets	Minutes and action notes from the Access Board made available from Southend CCG.	Increase in backlog of patients awaiting treatment
	Performance against metrics reviewed against the action plan to ensure actions appropriate or need for further mitigation plan.	Slippage against plans and timeframes without mitigation
	Jointly accountable to NHSE/I for delivery against the targets. Two weekly/Monthly review meetings in place with NHSI/E.	
CCG agreed plan to clear backlog	Monitoring of the backlog to ensure that numbers decrease , monitored via the Executive Meeting, Access Board, performance meetings and SUHFT Board	Lack of awareness of backlog position and actions to decrease the backlog
Development of a single work stream/division to manage the cancer pathway across the three sites; Southend, Basildon and Mid Essex.	Shared ownership of delivery against the targets with each organisation held to account for their part of the action plan/pathway delivery, whilst managed as one team.	Lack of information about the trust cancer pathway position on a patient by patient, speciality by specialty basis. Patients lost between the specialities or hospitals.
The A&E Delivery Board, chaired by SUHFT MD, with a focus on holding all providers to account for performance against the A&E standard and action against the 5 mandated interventions.	Action Plans for the 5 mandated interventions as per A&E delivery board. Organisations will be held to account for performance against the associated KPIs as part of the A&E Delivery Board.	Absence of the Board meeting and absence of actions to improve the position

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	Positive Assurance *Evidence that shows the controls are effective (e.g. metrics, inspections etc.)*	Negative Assurance *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
	Minutes and action notes from the A &E delivery Board	
	Key elements of actions shared in the performance report at the SUHFT Board	
OPERATIONAL CONTROLS; Weekly Cancer meeting & Weekly RTT/PTL meetings, from 1st May to be chaired by senior site leader/executive, with focused work in certain specialities. Weekly Urgent Care Board, chaired by senior site leader/executive, to review performance and delivery of internal actions against plan, track and monitor if outputs are making a difference.	Action log and performance report demonstrating delivery against work streams	Absence of the meetings happening and absence of actions identified being taken.
Trust/Clinical Directorate level balance scorecards and performance management Framework with monthly Directorate Performance Meetings	Integrated Performance Report is a standard agenda item on Board agendas – agenda and minutes	Lack of information in the monthly performance reviews of current status and individual directorate actions to improve performance
	Directorate Performance Review meeting action logs	
	Fortnightly Exec/CD meeting and weekly AD meetings	

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	Action plan and date for completion of action: *Specific actions with dates to address the gaps in controls or assurance*	Date Due
Greater focus on capacity at stages of treatment at speciality level/hospital level to improve efficiency / utilisation and prevention of 'late referrals' between the 3 hospital sites.	Revised Cancer action plan to encompass actions from all 3 sites, including the standardisation of pathways, monitoring and reporting processes.	End of July 2017

Risk 4	*Trust not being financially sustainable*			**Director lead:** Director of Finance	
	Link to Corporate Risk Register	***CQC Domain***	**Trust Strategic Objective:**	**Date last reviewed:**	19 April 2017
	2287, 2003, 2321, 2621, 2620	***Well-led***	**Financial and Operational Sustainability**	**Reviewed by Corporate Governance Group**	13 April 2017
				Reviewed by Finance and Resources Committee	26 April 2017
				By Board	8 December 2016

Risk Rating	**Likelihood**	**Consequence**	**Total**	25 20 15 10 5 0 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17
Initial	**5**	**5**	**25**	
Current	**4**	**5**	**20**	
Target	**3**	**5**	**15**	

Impact:

Unable to fund operational requirements and capital investments resulting in a deteriorating infrastructure.

Need to make cuts in expenditure which impact on service quality and cause operational disruption.

Imposition of regulatory controls and restrictions with the loss of local control.

Damage to reputation within the local community and wider NHS with subsequent difficulties in attracting good quality staff

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant assurance in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc). Relevant control in brackets*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.) Relevant control in brackets*
The agreement of budgets which balance within the Control Total and the management of these at the directorate performance reviews. This also includes the development of the Financial Improvement Plan supported by a Turnaround Director and PMO. This work is overseen by the Site Leadership Team and the Efficiency Sub-Committee.	Site Leadership Team agenda and minutes	The regular meetings with NHSI have not highlighted any significant specific action that the Trust is not already taking.
	Efficiency Sub-Committee action log	
	The Lord Carter review of 2014/15 shows the Trust to be in the lower range of costs for acute providers. (1) & (2)	
Monthly reporting of financial performance at Board level & scrutiny at quarterly Finance & Resources Committee	Board & FRC agenda and minutes	N/A
	The Trust's financial position for 2016/17 achieved the plan	N/A

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant assurance in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc). Relevant control in brackets*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.) Relevant control in brackets*
Monthly review of directorate performance by the Site Leadership Team	Directorate PRM action logs	N/A
Weekly cash forecasts and close monitoring of creditors and debtors with rapid escalation of difficulties where debts are not being settled.	The notes of the weekly Finance Management Group showing that the current cash position is being discussed	Absence of late payment charges (from suppliers) during 2016/17
	Case for Change document produced in conjunction with Grant Thornton.	N/A
Review of fixed assets and potential sale of property where appropriate.	Progress made in selling Fossets Farm and Board minutes.	N/A
Close management of investment / capital bids through the Investment Approval Committee and the Revenue Approval Committee	Investment Approval Committee and Revenues Approval Committee minutes / notes.	N/A
Exploration of all funding sources including leases and loans	Agreement with leaseguard and the increase in the volume of leases as evidenced made by the payment made under the general ledger.	N/A
The Trust has assessed the need for further cash support in 2017/18 and has arranged an uncommitted revenue support loan to address this.	Agreement of the loan with NHSI. Compliance with the Section 42 conditions which are a requirement of the loan.	N/A
Very close monitoring of the costs associated with the new Medical Model.	The detailed business case and meetings that have taken place between clinicians, senior managers and external advisors to arrive at the proposal. The recruitment to individual posts will be tracked and the use of agency kept to a minimum.	N/A

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	**Action plan and date for completion of action:** *Specific actions with dates to address the gaps in controls or assurance*	**Gap Ref**	**Date Due**
Unidentified cost-improvement balance of £0.5m	There are a number of additional schemes that are being developed	1	Jun 2017
Although the Trust has already contributed towards the running costs of the JEG and the project teams involved with developing the reconfiguration plans, there is still a great deal of uncertainty and there is a possibility that the three acute Trusts will be required to contribute more.	The Trust will monitor events closely and quickly identify any potential for the costs of ESR to grow.	2	ongoing

Risk 5	*Inability to recruit and retain staff*			***Director lead:*** *Director of Organisational Development and Human Resources*	
	Link to Corporate Risk Register	***CQC Domain***	**Trust Strategic Objective:**	**Date last updated:**	18th April 2017
	2623 and 2624	***Safe Effective Caring Responsive Well-led***	**Engaged and valued staff** **Financial and Operational Sustainability**	**Reviewed by Corporate Governance Group**	13 April 2017
				Reviewed by Finance and Resources Committee	1 March 2017
				Reviewed by Board	8 December 2016

Risk Rating	Likelihood	Consequence	Total
Initial	**5**	**5**	**25**
Current	**4**	**5**	**20**
Target	**3**	**5**	**15**

Impact:

Breach of licencing conditions

Regulatory action

Poorer patient outcomes

Adverse publicity/reputational damage

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc.) Relevant actions in brackets.*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
HR and Organisational Development strategy	Finance and Resources Committee	Ineffective action plans and strategy action plans not being met by due date
Recruitment Action Plan and trajectory	HoNs meeting, Board meeting, Execs meeting	Actions plans not delivering specific recruitment targets
Localised retention schemes in hard to recruit areas	(5)	Increasing turnover in specific areas
International and national Recruitment campaigns	SLA with recruitment agencies and contract monitoring	(2) not taking place
Targeted recruitment campaigns	SLAs with recruitment agencies and contract monitoring	No robust SLAs in place with specialist agencies for shortage occupation groups
Directorate and corporate staff survey action plans	Non-clinical and clinical PRMs, clinical Directorate Board meetings, OD and Education Board, Finance and Resources Committee	Directorates with no local action plans No assurance in OD and ED Board minutes that action plans are effective

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring. Relevant actions in brackets*	Positive Assurance *Evidence that shows the controls are effective (e.g. metrics, inspections etc.) Relevant actions in brackets.*	Negative Assurance *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
Values based recruitment (to ensure the right staff are employed)	(7)	No evidence of Values questions in sample of interview questions
On-boarding processes	(1)	Low attendance at Trust Induction
Exit interviews	(8)	Evidence of Directorates failing to complete exit interviews with leavers
Effective management processes and practices to aid retention	Staff friends and family test (FFT)	Poor or low response rates or participation in Staff FFT
Workforce dashboard	Reported at board (IPBR), directorate board meetings and directorate performance meetings	Incorrect data in dashboard, Dashboard and performance report not on agenda for board and directorate meetings
Revised appraisal process in place	(9)	Low numbers of appraisals taking place

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	Action plan and date for completion of action: *Specific actions with dates to address the gaps in controls or assurance*	Date Due
1. Revised on-boarding process not in place	Review of welcome day implemented pre-boarding and on-boarding policy currently being reviewed completion quarter 2 2016/17 ***The on boarding policy is now due for approval in November 2016*** January 17 Update – The on boarding policy has been approved and is now available on the Intranet	September 2016
2. Non-EU recruitment campaigns in progress	Non –EU recruitment campaigns commenced via waiver, full process in place in April 2016. Tender pending approval and will be approved in May ***September update – Tender has now been approved and international campaigns in progress***	May 2016
3. Revised Exit surveys process	Face to face exit interviews for all areas implemented in 2016/17 **January 17 update – An audit of exit interviews has now taken place**	Mar 2017
4. Review of terms and conditions	Undertake full review of local terms and conditions – review undertaken to be presented to Board in July 16 ***September Update – This review has taken place and was presented to board in July***	Jul 2016
5. Test effectiveness of local retention schemes	Conduct audit of local R&R schemes, review impact on retention and attraction rates **January 17 Update** - Review is on-going and being discussed as part of the Trust's pay review discussions	Mar 2017

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	**Action plan and date for completion of action:** *Specific actions with dates to address the gaps in controls or assurance*	**Date Due**
6. Test effectiveness of targeted recruitment campaigns	Start capturing how applicants heard about us ***(this is now in place)*** ***October Update – Review will be undertaken in January 2017*** ***January 17 update - Review has been undertaken in January 2017, results are being analysed and a report will be provided at the end of February 2017. Due to changes in the team this analysis has not taken place , will now be done in June 2017***	Sep 2016
7. Value based recruiting	Include some sample value based questions as part of the recruitment pack for managers ***October Update – This is due to be completed by December 2016*** ***January 17 Update – Sample questions are now available via Trac and this will be included in the recruitment training for Managers currently being rolled out across the Trust***	Oct 2016
	Undertake sample check of questions asked by interview panels to ensure values questions are being asked. This is being arranged for June 2017.	Mar 2017
8. Exit interviews	Audit of exit interviews **January 2017 - This has now taken place**	Dec 2016
9. Revised appraisal process	Audit of appraisal process (staff Feedback)	June 2017

Risk 6	*The ageing buildings, physical environment, associated infrastructure and inadequate backlog resources presents an almost certain risk of services failing and impacting on the delivery of patient services*		**Director lead:** Director of Estates and Facilities	
	Link to Corporate Risk Register	**Trust Strategic Objective:**	**Date last updated:**	5 April 2017
	2359	**Excellent patient outcomes** **Excellent patient experience** **Engaged and valued staff** **Financial and operational sustainability**	**Reviewed by Corporate Governance Group**	6 April 2017
			Reviewed by Quality Assurance Committee	19 April 2017
			Reviewed by Board:	8th December 2016
			Reviewed by EFM Board	6th February 2017

Risk Rating	Likelihood	Consequence	Total
Initial	**4**	**5**	**20**
Current	**3**	**4**	**12**
Target	**3**	**3**	**9**

25
20
15
10
5
0
Oct-15 Apr-16 May-16 Jul-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17

Impact:

Breach of licencing conditions

Regulatory action

Poorer patient outcomes

Adverse publicity/reputational damage

Key controls/mitigation *What we are currently doing to reduce the impact or likelihood of the risk occurring*	**Positive Assurance** *Evidence that shows the controls are effective (e.g. metrics, inspections etc)*	**Negative Assurance** *Evidence we won't find if the controls are effective (e.g. incidents, complaints etc.)*
1. All EFM Services policies and procedures linked to statutory requirements are in place	Policies updated within required timescales, annual audits to confirm implementation and action plans where required. Evidence available for HSE and CQC inspections. Premises Assurance Model completed with identified action plan. (1)	Significant risk / Non Conformances established by ISO 9001 and 18001auditors, the outcome of audits contained in QAMG minutes. Gaps in Premises assurance model outcomes.

2. EFM Training to ensure the workforce has the skills required to maintain the estate and to support the appointment of Authorised Persons and or Competent persons.	Training skills register demonstrates compliance (2)	Gaps in appointed Authorised persons.
3. Hard Services – Statutory Compliance Processes Asset register, annual Planned Preventative Maintenance (PPM) programme in place.	CAFM holds Asset register and annual programme of PPM, KPI audit reports submitted to the Trust Board Estates Risk Assessed Capital Programme prioritises investment to remove high risk statutory items. Action plans available linked to incident reporting (3)	ISO 9001 and 18001 significant risk Non Conformances. Increasing high and significant costs to manage risks as per Estates Code guidance and reported in the annual estates strategy
Internal and external audit by Authorising Engineer (AE).	Internet Access to Hard Services Tasks / response times and performance now available for staff / managers to monitor progress	**N/A**
Six Facet Condition Survey / Backlog Capital Programme / Incident reporting system	Six Facet Survey (4)	A high percentage of dissatisfaction in customer surveys
4. Soft Services – Cleaning Standards Standard operating procedures monitored by domestic supervisors Internal QA uses C4C to monitor cleaning standards for domestic and nursing staff	C4C Audit reports are sent to the services and action plans developed / implemented Repeat unannounced audits undertaken to ensure actions are completed KPI reports to QAC/ H+S and the Trust Board	Uncompleted action plans to address cleanliness issues. Infection control outbreaks linked to poor cleaning standards **N/A**

5. Contract Monitoring	KPI clearly identified in contract specification and reviewed at monitoring meetings	Limited assurance from QAC
6. Business Continuity Plans	Incident reporting, Emergency Planning Exercises result in revision of plans	Uncertainty in actions taken in the event of a major failure of business systems impacting on patient safety
7. Security – risk of failing system due to age	Site wide audit completed – security strategy approved by CMT. Five year investment plan agreed for years 1-5 and placed on capital plan. Reports reviewed H&S Committee and CMT. Risk assessment action plans agreed in High Risk areas CRT training in place	Instances of security breaches that do not have a corresponding plan to address. A gap in identified training need. **N/A** **N/A**
8. All assets are risk assessed and managed via the capital replacement programme	Risk assessed capital programme in place	Unexpected failure of assets that are beyond life expectancy and identified for replacement.
9. Medical Equipment – policy in accordance with MHRA guidance. ISO 9001 registered. Asset register, risk assessed PPM programme. Control over purchase and disposal of equipment. Evidenced user training programme. Equipment condition/fitness for purpose annually risk assessed for inclusion in capital programme. Equipment related incidents investigated.	Monthly performance KPI's reported to board Internal audit schedule External (BSI) audit schedule Quarterly medical devices safety report Risk assessed capital programme	Major failure of equipment impacting patient care Instances of equipment impacting patient care being unavailable Incidents involving medical devices

Gaps in Control or Assurance *What needs to be done to improve controls or assurance*	**Action plan and date for completion of action:** *Specific actions with dates to address the gaps in controls or assurance*	**Gap Ref**	**Date Due**
1. Completion of PAM	Estates and its related services are integral to the delivery of high quality, safe, effective and efficient clinical care. The 2016 NHS Premises Assurance Model (PAM) has been updated to reflect changes in policy, strategy, regulation, technology and supports the NHS Constitutional right: ***'You have the right to be cared for in a clean, safe secure and suitable environment'.***	1	June 2017
2. Appointment to Medical Gas AP has expired with the current incumbent retiring. The services are currently being provided by BOC on an ad-hoc basis.	Quotations for the provision of AP services received, appointment to be made. Engage AP	2	May 2017
3. Updated capital plan	Plan under development, to be signed off by end April 2017. Risks not addressed to be highlighted to QAC	3	May 2017
4. 6 Facet Survey is due for refresh	Progress and complete survey	4	June 2017