SUMMARY REPORT	Meeting Date:	24th November 2016
	Agenda Item:	10.5
	Enclosure Number:	13

Meeting:	**Board Meeting**		
Title:	**Governance Report**		
Author:	**Peter Foord, Corporate Risk Manager**		
Accountable Director:	**Julie Thornby, Director of Corporate Affairs, Peter Phillips, Non Executive Director and chair of the Audit Committee**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Audit Committee	4th October 2016	The Audit Committee reviewed the Board Assurance Framework (BAF).
	Quality and Safety Committee	17th November	The committee reviewed and agreed the risks related to the CQC inspection report.

Purpose of the report		
Section 1 Governance Report • To present the Board with the latest versions of the Board Assurance Framework (BAF) and Corporate Risk Register so that Board members can consider if they effectively capture our main risks, and give Board members enough assurance about how we are mitigating risks affecting our organisational objectives. • To highlight changes made to risks related to the CQC inspection report. • To highlight other governance activities and issues, including the Hospitality Report. **Section 2 Audit Committee Report** • Summarise assurances and issues from discussions of the Audit Committee held on October 4th 2016. .	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community**

			services
✓			✓

Summary of key points in report

Section 1 Governance Report

Changes to the Board Assurance Framework

- The Audit Committee recommended that the Resources and Performance Committee closely review the entry for Meeting Financial Targets.

Changes to risks arising from the CQC Inspection Report

- The current rating for Clinical Quality on the BAF has been increased from 6 to 9. A gap in assurance has been added to reflect the CQC rating.
- Three risks have been added to the Corporate Register for End of Life processes, Staffing/Skill mix and Leadership Skills/Supervision.
- Divisional Risk Registers have been updated to include risks related to MIU, Patient Acuity and CAMHS staffing and service delivery.
- Changes have been agreed by the Quality and Safety Committee.

Other changes to Corporate Risk Register

- One risk has been added to the register, for Non Compliance with the Annual Leave Policy. The risk relates to situations where staffing is compromised by staff taking annual leave at the same time.

Section 2 Audit Committee Report

- The Committee received and approved the Annual Hospitality Report.
- The Security Management Strategy was approved.
- Five Internal Audit reports were received, three were given reasonable assurance, one substantial assurance and one was an advisory report. Recommendations have been agreed and are being actioned.
- The committee received the Clinical Audit report. Assurance was given for the audit planning processes and matching audits to risks
- The committee received the Community Services Divisional Risk Register and were satisfied that processes are in place for the identification and mitigation of risk.
- The annual Audit Committee report was agreed. The report concludes that the Trust has an effective system of internal control in place, and where deficiencies are identified action is taken to make improvements.

Key Recommendations

Section 1. Governance Report

- **Consider** the latest changes to the Board Assurance Framework. Are current significant risks to strategic objectives, including those detailed in the CQC report accurately captured in the **Board Assurance Framework/Corporate Risk Register** and does it give sufficient assurance on risk mitigation?
- **Approve** the framework.

Section 2 Audit Committee Report

- **Note** the conclusions of the Hospitality report
- **Consider** the assurances and conclusion contained in the Audit Committee Annual Report to the Board

Is this report relevant to compliance with any key standards? YES OR NO		State specific standard or BAF risk
CQC	Yes	Aspects of Governance are included within the standards for Safeguarding and Safety, Suitability of Staffing and Quality and Management.
IG Governance Toolkit	No	
Board Assurance Framework	Yes	Relates to all entries

Impacts and Implications?	YES or NO	If yes, what impact or implication
Patient safety & experience	Y	Good governance processes will have a positive impact on the safety and quality of patient care.
Financial (revenue & capital)	Y	The Board Assurance Framework details major financial risk which could impact on the Trust objectives.
OD/Workforce	N	Inter-relationship between OD and workforce issues and quality
Legal	N	Various potential legal risks if issues are not managed effectively

SECTION ONE: GOVERNANCE REPORT INCLUDING BOARD ASSURANCE FRAMEWORK

Board Assurance Framework (BAF)

1.1 Audit Committee Recommendations from October meeting

1-2014. Clinical Quality: The committee noted that the entry will need updating to reflect the CQC report.

6-2014 Meeting Financial Targets: The committee recommended that the Resources and Performance Committee keep the risk under close review.

1.2 Changes made since the last Board meeting

Section 1.3 details changes made to both the BAF and Corporate Register to reflect the CQC inspection report. These changes have been discussed at the November Quality and Safety Committee.

Changes to all BAF risks are detailed in the table below:

Ref	Title	Changes
7-2014	Changing Culture	Assurances updated to reflect CQC report, staff sickness position and appointment of Freedom to Speak up Guardian
1-2014	Clinical Quality	Current rating increased from 6 to 9 to reflect CQC rating of requires improvement. Gap in assurance added to reflect the report conclusion.
6-2014	Meeting Financial Targets	No changes
11-2015	Recruitment/Agency costs	No changes
1-2016	Transformation - Local and National Contexts	Risk controls updated with latest STP position for the development of community services and outline finances, and the Trust plan
3-2014	Transformation - Systems	Target rating changed to show consistent consequence throughout ratings. Score has not been changed.
5-2014	Trust Sustainability	Gap in assurance changed to aligning STP to Trust plans

1.3 Changes to the BAF and Corporate Register as a result of the CQC inspection.

Board Assurance Framework

Risk 1-2014 Clinical Quality

The risk was updated in January 2016 as an overall quality risk, rather than specifically listing quality challenges e.g. pressure ulcers, falls and CAMHS pressures. The risk is supported by risks on the corporate and divisional registers, which detail the individual quality components and the detailed controls and planned actions to address challenges.

CQC rating of requires improvement has been added to Gaps in Assurance. Delivery of the CQC action plan is under the listed actions to address the gap. The current risk score has been increased from 6 to 9. The change in score comes from the likelihood being increased from 2 to 3 reflecting the rating of "requires improvement". This change was approved at the November Quality and Safety Committee. As the CQC action plan is progressed, the score will be reduced. It is not proposed to make any further changes at this stage. The BAF is attached as **Appendix 1.**

Corporate Risk Register

It is proposed to add three new risks to the Corporate Register, as they relate to Trust processes rather than individual service risks:

- End of life Processes

Details the need for an overall End of Life Strategy, and have a process for the review of End of Life risks and incidents.

- Staffing/Skill mix.

Details the areas raised for CAMHS, and Community Services.

- Leadership Skills/ Supervision.

Details the areas identified for communication with managers and clinical supervision.

In addition to the above an additional action has been added to the entry for Board Leadership to reflect the need for improvement in assurances and knowledge of risks and risk management.

As well as the BAF and Corporate Register risks have been added to the Community Hospital and Outpatient Divisional registers. These risks are:

- MIU conformity with standards and staffing
- Patient acuity management within the community hospitals

Three risks have been added to the Child and Family Division Register. These risks reflect those related to the CAMHS tender, and the staffing and service delivery issues raised within the CQC report. The risks are:

- Risks associated with not winning CAMHS tender
- Transition of services to new CAMHS working model
- CAMHS Recruitment and staffing problems

The changes were agreed by the November Quality and Safety Committee

1.4 Corporate Risk Register

Lead Directors have reviewed their entries on the Corporate Risk Register. Other than the changes detailed in 1.3 one risk has been added to the register, for Non Compliance with the Annual Leave Policy. The risk relates to situations where staffing is compromised by staff taking annual leave at the same time. Actions identified are for an audit to measure scope of the risk, and for information to be entered onto ESR to allow ongoing monitoring.no other significant changes have been made. The register is attached as **Appendix 2**.

1.3 Use of the Trust Seal

The seal has not been used since the last meeting.

SECTION TWO: AUDIT COMMITTEE REPORT

2.0 The Audit Committee met on the 4th October 2016. Below is a summary of the key points of the meeting and assurance gained:

2.1 **Cyber Security Risk**. The committee received a report from the IMT Manager. This detailed the measures in place to protect Trust systems. The committee heard that a Committee member had attended an RSM Audit presentation on the risks associated with cyber security, which they had found very useful. It was agreed that a similar presentation would be arranged for the Board (provisionally February/March).

2.2 **Service Level Agreements**. The committee were informed that the Finance team post responsible for the management of SLAs has been recruited to, and work on the register was progressing.

2.3 **Annual Hospitality Report**. The committee received and accepted the assurances given by the report. As the largest area for pharmaceutical sponsorship is the Diabetes service the committee requested the service manager attend its January meeting to report on this area. The summary of the register is attached as **Appendix 3.**

2.4 **Security Management Strategy**. The committee received the Security Management Strategy. The strategy was approved and the committee was assured of the detailed processes in place to protect all stakeholders in relation to Trust property and assets.

2.5 **Internal Audit**. The committee received the Internal Audit progress report. Five reports were summarised:

- Action Tracking: Advisory report, the committee requested that for future reports actions which had a high priority should be highlighted.
- Risk Management, Community Hospitals and Outpatient Service Risk Register: Reasonable Assurance was given.
- Service Delivery Groups: Reasonable Assurance
- IT Cyber Security: Reasonable Assurance
- IT Key Financial Systems: Substantial Assurance

Where improvements have been recommended actions plans have been agreed and are in progress.

2.6 **External Audit**. Auditors presented their progress report. This highlighted a number of national reports including Brexit, the direction of Primary Care, the direction of Sustainability and Transformation Plans, NHS finances and Vanguards in New Care Models and Strengthening Financial Performance and Accountability. Further information is available from auditors if required. Auditors will be working with the Trust over the next 3 months in compiling the plan for the 2016/17 audit.

2.7 **Annual Clinical Audit Report**. The committee received the report. A description of how the plan was compiled was given, and how audits were prioritised. Enquiries were made on how recommendations were followed up, and how the plan related to risks. Improvements are to be made in the coming year on action completion tracking, status of audits and relationship with identified risks. Then committee accepted the report as assurance that processes are in place for manage clinical audit.

2.8 **Board Assurance Framework**. This is included in Section 1, Governance Report.

2.9 **Corporate Risk Register**. Members discussed the risk for staff appraisals. The committee noted that significant work has been done and highlighted the importance of ensuring that there is ongoing emphasis on appraisal within services.

2.10 **Directorate Risk Register.** The committee received a presentation on the Community Services register. Risks were highlighted for the provision of community equipment, reporting on ICS performance indicators, ICS admissions avoidance and end of life pathways. Top risks are reviewed monthly at the Divisional Quality and Safety Meetings. The committee were assured of the processes in place for risk identification and mitigation within the Community Services Division.

2.11 **Annual Report to the Board.** The committee approved the annual report about its activities to the Board. The report includes a summary of the committees activities, the assurances received and concludes that an effective system of internal control is in place, and that where deficiencies are identified measures are put into place to remedy them. The report is attached as Appendix 4.

3. RECOMMENDATIONS TO THE BOARD

Section 1. Governance Report

- **Consider** the latest changes to the Board Assurance Framework. Are current significant risks to strategic objectives, including those detailed in the CQC report accurately captured in the **Board Assurance Framework/Corporate Risk Register** and does it give sufficient assurance on risk mitigation?
- **Approve** the framework.

Section 2. Audit Committee Report

- **Note** the conclusions of the Hospitality report
- **Consider** the assurances and conclusion contained in the Audit Committee Annual Report to the Board

BAF Index September 2016

Appendix 1

Principal objectives	Ref	ID	Title	Rating (current)	Lead Director	Monitoring Group	Page
: Assurance Framework							
EFFICIENT - We will review services to deliver as efficiently as possible enabling reinvestment in patient care.	5-2014	1996	Trust Sustainability	16	Ros Francke	Resource and Performance Committee	4
SAFE - people are protected from abuse and avoidable harm.	11-2015	2319	Recruitment/Agency costs	15	Gregory, Mr Steve	Quality and Safety Committee	8
GROW - we will seek opportunities to extend the range and scale of services delivered in the community.	1-2016	2752	Transformation - Local and National Contexts	15	Mel Duffy	Resource and Performance Committee	10
EFFICIENT - We will review services to deliver as efficiently as possible enabling reinvestment in patient care.	6-2014	1997	Meeting Financial Targets	12	Ros Francke	Resource and Performance Committee	6
WELL LED - the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, support learning and innovation, and promote an open and fair culture	7-2014	1998	Changing Culture	12	Ditheridge, Ms Jan	Quality and Safety Committee	7
MAKING BEST USE OF TECHNOLOGY - we will deploy technology to improve patient care and increase efficiency ensuring the right information is available to the right people at the right time regardless of the care setting.	3-2014	1994	Transformation - Systems	8	Ros Francke	Resource and Performance Committee	3
SAFE - people are protected from abuse and avoidable harm. RESPONSIVE - services are organised so that they meet people's needs. EFFECTIVE - Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence DELIVERED IN SUITABLE ENVIRONMENTS - we will review the use of our estate and develop where appropriate	1-2014	1992	Clinical Quality	9	Gregory, Mr Steve	Quality and Safety Committee	1

Rating (current)

The direction of the arrow shows the lead director's opinion of the risk direction:

The colour within the arrow shows the current level of risk: High, Moderate, Low, Very Low

Objectives with no risks currently identified

CARING – staff involve and treat people with compassion, kindness, dignity and respect.
DESIGNED AROUND THE PATIENT - Our services will be continually reviewed and modified placing the patient at the centre of the redesign. Working across organisational boundaries to deliver integrated care.

BAF – Assurance Status

Ref	ID	Title (Policies)	Rating (current)	Risk level (current)	Manager	Assurance (Assurance)	Assurance Rating	New Assurances
7-2014	1998	Changing Culture	12	MOD	Ms Jan Ditheridge	HR statistical reports		Rolling 12 month sickness figure slightly improved but short term sickness remains problematic
						Trust dashboard		As above
						Staff Survey and culture barometer		Staff Survey Action plan being delivered and monitored by the culture group
						Responses to national initiatives and guidance		Human Factors group established
						Reviews by Regulators		CQC rating- requires improvement, action plan now in place
						New Freedom to Speak Up Guardian		Post recently filled; developing accountability and responsibility across the organisation
1-2014	1992	Clinical Quality	6	LOW	Mr Steve Gregory	Summary reports for quality standards, Q&S Committee and Board		No new assurances
						Monthly Clinical Quality Reviews by Commissioners		No new assurances
						Reviews by regulators, actioned when necessary		CQC rating, requires improvement
						Visits and reports by Healthwatch		No new assurances
						Quality Account		Completed
						Annual reports - Clinical Audit, Mortality, Medicines, Health and Safety		No new assurances
						Infection Prevention and Control Group (reports)		No new assurances
						Board to team visits		Ongoing program
						LA Safeguarding Boards (4) scrutiny of Trust arrangements		No new assurances
6-2014	1997	Meeting Financial Targets	12	MOD	Ms Ros Francke	External audit of accounts		No new assurances
						External value for money audit		No new assurances
						Financial systems audit by internal auditors		No new assurances

						Financial reports to Board		Financial Targets on track
						Internal audit of CIP process		No new assurances
11-2015	2319	Recruitment/Agency costs	15	HIGH	Mr Steve Gregory	Financial and performance reporting		Current position within NHSi target
						Staffing and workforce reports		No new assurances
						Trust Wide Agency Working Group		No new assurances
						Monitoring against the NHS I target indicates a reduction in expenditure in targeted areas of agency spend		As described
1-2016	2752	Transformation - Local and National Contexts	15	HIGH	Ms Mel Duffy	Progress reports to Board/R&P		No new assurances
						STP program director reports		No new assurances
						STP Partnership Board minutes		No new assurances
3-2014	1994	Transformation - Systems	8	MOD	Ms Ros Francke	Project reports to Board via R&P		The project is very much on plan in all respects other than configuration which is currently a working week behind. The ability to catch up with this is entirely predicated on additional resource being approved to support this work which is being considered by RPC on Monday
						Business cases reported via R&P		No new assurances
						Formal project structure and reports to R&P/Board		As project reports
						EPR business case approved formally by NHSi		Complete
5-2014	1996	Trust Sustainability	16	HIGH	Ms Ros Francke	Implementation of strategic workstreams		No new assurances
						Contract negotiations concluded for 16/17 with main local commissioners		Completed

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 1-2014 **Clinical Quality** **Lead** **Mr Steve Gregory** **Initial rating** 12 **Current rating** 9 **Target rating** 6 **Risk Indicator** ▼

Datix ID 1992 **Non Exec. Lead** **Rolf Levesley** **C x L** 4 X 3 **C x L** 3 x 3 **C x L** 3 x 2

Changes since last update Current rating increased from 6 to 9 to reflect CQC rating of requires improvement. Gap in assurance added to refect the report conclusion.

Objective	Risk	Controls	Assurance		Gaps in Control	Gaps in Assurance
SAFE - people are protected from abuse and avoidable harm.	RISK Quality of care fails to meet the needs and expectations of public. Quality of care does not meet targets set by commissioners. Financial constraints compromise quality and safety. CQC standards not met. CONSEQUENCE Harm caused to patients. Increased time and cost of patient care. Loss of public confidence. Enforcement action by regulators. Services lost to other providers. Litigation time and costs. Increased staff turnover, difficulties with recruitment. Increased waiting times	Monitoring of quality standards, e.g. CQUINS, pressure ulcers, falls, VTE assessment and treatment, UTIs, waiting times. Quality impact assessment for service changes. Clinical Audit program. Divisional challenge meetings related to quality. e.g. CQC, Pressure ulcers. Quality improvement initiatives. e.g Harm free care. Trustwide self monitoring of standards. Quality performance monitoring, MPR, Dashboard, Incidents. complaints and claims monitoring, Safety Thermometer Investigation and subsequent actions from SIs, complaints, claims and unexpected death reviews/Mortality Group review Staff training (mandatory and essential skills) Infection prevention and control workplan. SPC reporting in place to identify outlying events Safeguarding arrangements in place (training, reporting, supervision and internal group monitoring) Good to great project commenced, regular monitoring/checking and compliance visits.	NON INDEP INDEP INDEP NON NON NON NON INDEP	Summary reports for quality standards, Q&S Committee and Board Monthly Clinical Quality Reviews by Commissioners Reviews by regulators, actioned when necessary Visits and reports by Healthwatch Quality Account Annual reports - Clinical Audit, Mortality, Medicines, Health and Safety Infection Prevention and Control Group (reports) Board to team visits LA Safeguarding Boards (4) scrutiny of Trust arrangements		Control of Estates Management CAMHS CQC rating of "required improvement"

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

CQC Links

E1: Are people's needs assessed and care and treatment delivered in line with legislation, standards and evidence-based
E2: How are people's care and treatment outcomes monitored and how do they compare with other services
E3: Do staff have the skills, knowledge and experience to deliver effective care and treatment?
E4: How well do staff, teams and services work together to deliver effective care and treatment?
E5: Do staff have all the information they need to deliver effective care and treatment to people who use services?
E6: Is people's consent to care and treatment always sought in line with legislation and guidance?
R3: Can people access care and treatment in a timely way?
R4: How are people's concerns and complaints listened and responded to and used to improve the quality of care?
S1: What is the track record on safety
S2: Are lessons learned and improvements made when things go wrong
S3: Are there relliable systems, processes and practices in place to keep people safe and safeguarded from abuse
S4: How are risks to people who use services assessed and their safety monitored and maintained
S5: How well are potential risks to the service anticipated and planned for in advance

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
CAMHS:Work with commissioners to agree service model that meets patient need. This will ensure that we have the right staff with the right skills.	Completed	*Service is going out to tender, so this action is no longer relevant*	31-May-2016	
As part of CQC arrangements evaluation recruit 2 heads of Nursing and Quality. Review arrangements in 6 months	Completed	*Staff appointed for further 6 months, review scheduled for December*	31-Jul-2016	
Review of Facilities and Estates service to take place. Review of the Estate we operate from. E.g. leased properties	In progress	*Estates Strategy will be completed by the end of August*	31-Aug-2016	
Formulate action plan following receipt of CQC report	Pending	*Report received, quality summit 9/9, action plan to be developed by 7/10*	7-Oct-2016	

Residual Risks

Monitoring Group Quality and Safety Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 3-2014 **Transformation - Systems** **Lead** **Ms Ros Preen** **Initial rating** 12 **Current rating** 8 **Target rating** 6 **Risk Indicator** ▲

Datix ID 1994 **Non Exec. Lead** **Steve Jones** **C x L** 3 X 4 **C x L** 2 x 4 **C x L** 2 x 3

Changes since last update Target rating changed to show consistent consequence throughout ratings. Score has not been changed.

Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
MAKING BEST USE OF TECHNOLOGY - we will deploy technology to improve patient care and increase	RISKS Trust is not able to develop information systems to meet future service needs. Trust currently uses a mixture of manual and electronic systems leading to productivity, data capture and data quality issues. Multiple systems not allowing cross discipline record keeping. Lack of opportunity for mobile working. Contractual negotiations with EPR supplier are nearing completion. Issues remain regarding liability indemnity CONSEQUENCES Services do not develop fast enough. Potential financial risks associated with tariff payments. Costs of system development.	Development of system specifications. Governance arrangements in place for managing the introduction of EPR systems Introduction of interim work around's Development of electronic workplace scheduler tool Use of manual recording systems	NON Project reports to Board via R&P NON Business cases reported via R&P NON Formal project structure and reports to R&P/Board INDEP EPR business case approved formally by NHSi	As service transformation becomes more defined, systems will need to be developed to meet service needs, which may identify risk where further controls need to be implemented.	

CQC Links
E4: How well do staff, teams and services work together to deliver effective care and treatment?
E5: Do staff have all the information they need to deliver effective care and treatment to people who use services?
S4: How are risks to people who use services assessed and their safety monitored and maintained
W4: How are services continuously improved and sustainability ensured

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Progress EPR solution	In progress	*EPR business has been signed off by TDA. The Trust is now reporting key deliverables, especially benefits realization, to NHS I through its regular IDM meetings.*	31-Mar-2016	Peter Foord

Residual Risks Ability to respond to new data requirement e.g from commissioners and national bodies. Technological limitations between data systems.

Monitoring Group Resource and Performance Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*
Ref No 5-2014 **Datix ID** 1996	**Trust Sustainability**	**Lead** Ms Ros Preen **Non Exec. Lead** Steve Jones	**Initial rating** 20 C x L 4 X 5 **Current rating** 16 C x L 4 x 4	**Target rating** 8 C x L 4 x 2	**Risk Indicator** ▼
Changes since last update	Gap in assurance changed to aliging STP to Trust plans				
EFFICIENT - We will review services to deliver as efficiently as possible enabling reinvestment in patient care.	RISKS Trust does not grow sufficiently to sustain its services. Block contracts, rather than tariff, do not meet increases in demands. Service tenders are awarded to other providers. Local commissioners deficit lead to reductions in our block contract which materially impacts on our contract income Trust fails to diversify to reduce risks associated with a constant service base. CONSEQUENCE Trust cannot sustain its overhead costs and remain competitive.	Ongoing contract discussions with commissioners, including changes in demand. Efficiency - focus on reduction of overhead costs. Process to identify tender opportunities. Local health economy DoF group. Development of closer working relationships with commissioners at all levels. Investment policy in place to focus business development resource on appropriate areas for growth. Business Development Group stronger role and tighter relationship with R&P, CIP Delivery Group and Transformation Board Business Investment Policy clarifies decision making process and level of delegation. Engagement in the planning requirements of a 5 year LHE sustainability and transformation plan (also added as an action to Transformation risk) Refresh of LTFM to review the Trust's long term financial position underway	INDEP Implementation of strategic workstreams NON Contract negotiations concluded for 16/17 with main local commissioners		A more developed STP financial plan which aligns to the Trust Planning submissions to NHSi and contracts in place.

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

CQC Links

C1: Are people treated with kindness, dignity, respect and compassion while they receive care and treatment

W1: Is there a clear vision and a credible strategy to deliver good quality

W2: Does the governance framework ensure that responsibilities are clear, and that quality, performance and risks are understood and managed?

W4: How are services continuously improved and sustainability ensured

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Develop a timetable and implementation plan for a system to produce service line reporting. This will be influenced by the timescales for the implementation of the EPR system and the development of the costing system which was bought in March 2016. The new costing/ contracting accountant is putting a time table together and this will determine the due date for this action.	In progress	*In progress*		Ms Ros Preen
Complete roll out of ICS and secure recurrent funding	Completed	*Funding secured*	31-Mar-2016	Mr Steve Gregory
Increase understanding of capacity and demand to inform negotiation of block contracts	In progress	*This was reviewed as part of the contract negotiations for 16/17 with commissioners. No material changes were required and 15/16 out turn was used to inform the baseline plan for the block contract.*	31-Mar-2016	Peter Foord
Development of the 5 year Financial Strategy	Completed	*Initial plan submitted to commissioners*	30-Jun-2016	Peter Foord
Implementation and review of new MSK service	In progress	*Implemented, review needs completing at 12 months, report due 31/12/2016*	31-Dec-2016	Mr Steve Gregory

Residual Risks

Ongoing LHE financial challenges. Potential for tendering of services by commissioners

Monitoring Group

Resource and Performance Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 6-2014 **Meeting Financial Targets** **Lead** Ms Ros Preen **Initial rating** 25 **Current rating** 12 **Target rating** 9

Datix ID 1997 **Non Exec. Lead** Steve Jones **C x L** 5 X 5 **C x L** 3 x 4 **C x L** 3 x 3

Risk Indicator ▶

Changes since last update No changes

Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
EFFICIENT - We will review services to deliver as efficiently as possible enabling reinvestment in patient care.	RISK Trust fails recurrently to meet targets for CIPs, breakeven, external finance limit, capital expenditure or agreed surpluses. There are challenges in both long and short term. CONSEQUENCE Long term future and viability compromised. Service quality affected by financial constraints.	Financial monitoring by managers, reported to R&P Long Term Financial Model (LTFM)completed in August 2016 CIP program and monitoring. Renewed focus and emphasis on CIP development and implementation. Forward CIP plan being developed. PMO function in place. CIP delivery group and Transformation Board in place. Financial Forecasting - reported to R&P and Board Capital and Estates Group in place to manage capital expenditure. Cash Management Processes to manage EFL well developed. CIP escalation process in place and meetings held. Non recurrent measures to be identified to offset shortfalls against recurrent CIP in short term, although underlying position is still affected. QEIA process in place including NED membership.	INDEP External audit of accounts INDEP External value for money audit INDEP Financial systems audit by internal auditors NON Finanical reports to Board INDEP Internal audit of CIP process	CIPs not fully developed for 16/17 Rolling programmes of efficiencies not yet in place	

CQC Links
W2: Does the governance framework ensure that responsibilities are clear, and that quality, performance and risks are understood and managed?
W4: How are services continuously improved and sustainability ensured

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Fully develop CIP program for 16/17. *Several schemes have had to be re-worked or new schemes developed to mitigate gaps in the programme.* *The significant scheme relating to IDT's has now got external resource to implement and this does not complete until December. Due date updated to reflect this.*	In progress	*Delivery of the Trusts targets are being delivered via a mixture of original CIP programme and non- recurrent measures.*	31-Dec-2016	Ms Ros Preen

Residual Risks Local health economy financial challenges

Monitoring Group Resource and Performance Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 7-2014 **Changing Culture** **Lead** Ms Jan Ditheridge **Initial rating** 16 **Current rating** 12 **Target rating** 8 **Risk Indicator**

Datix ID 1998 **Non Exec. Lead** Mike Ridley **C x L** 4 X 4 **C x L** 4 x 3 **C x L** 4 x 2

Changes since last update Assurances updated to reflect CQC report, staff sickness position and appointment of Freedom to Speak up Guardian

Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
WELL LED - the leadership, management and governance of the organisation assure the delivery of high quality	RISKS Staff aren't happy at work leading to poor patients care, reduced capacity (through sickness absence) and reduced opportunity for innovation and change. Potential risk that staff are reluctant to be open about incidents or practices Not seen as an organisation people want to work for - reducing capability and capacity. Reputation and relationships poor. CONSEQUENCES Trust does not deliver new care models to meet changing needs of patients/carers and commissioners. Organisation becomes unsustainable.	Leadership: Board messaging and visibility. Leadership programme and structure (e.g., CTLG) Organisational Development Framework activities Staff Health and Wellbeing Programme. Speak Out Safely/Freedom to Speak Up policies. Supporting HR policies - e.g. Whistleblowing. Actions will be integrated into Culture Work plan if new issues arise not covered in the plan Staff awaydays completed Patient and external feedback(complaints, PALs, See and Act Healthwatch reports)	NON HR statistical reports NON Trust dashboard INDEP Staff Survey and culture barometer NON Responses to national initiatives and guidance INDEP Reviews by regulators NON New Freedom to Speak up Guardian		

CQC Links
C1: Are people treated with kindness, dignity, respect and compassion while they receive care and treatment
C2: Are people who use services and those close to them involved as partners in their care?
C3: Do people who use services and those close to them receive the support they need to cope emotionally with their care, treatment or condition?
E3: Do staff have the skills, knowledge and experience to deliver effective care and treatment?
E4: How well do staff, teams and services work together to deliver effective care and treatment?
R2: Do services take account of the needs of different people, including those in vulnerable circumstances?
R4: How are people's concerns and complaints listened and responded to and used to improve the quality of care?

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Establishment of professional services group across health and social care	Completed	*Discussions held with social care, have been invited to professional leadership meeting.*	22-Sep-2016	Peter Foord

Residual Risks

Monitoring Group Quality and Safety Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 11-2015 **Recruitment/Agency costs** **Lead** Mr Steve Gregory **Initial rating** 20 **Current rating** 15 **Target rating** 12 **Risk Indicator** ▲

Datix ID 2319 **Non Exec. Lead** Rolf Levesley **C x L** 5 X 4 **C x L** 5 x 3 **C x L** 4 x 3

Changes since last update No changes

Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
SAFE - people are protected from abuse and avoidable harm.	RISK Difficulty in recruiting staff to Community Hospitals, Prisons, CAMHS and ICS. Increased use of both short and long term agency staff leading to risk of significant premium payments that the Trust has not got resource to cover. NHS Improvement have issued guidance on the use of agency staff which is designed to reduce the risk of material premium rates and the enhanced use of frameworks. They have set a target for the Trust not to exceed in 16/17. CONSEQUENCE Potential for increased patient safety risks. Additional agency spend is outside NHSi target. If internal controls are not sufficient then there is a risk that the Trust will incur a financial penalty associated with the Sustainability and Transformation Fund in 16/17.	Backfilling with agency staff to ensure safe staffing levels Recruitment campaigns Control techniques to reduce patient safety risk e.g. mix of permanent and agency, long term staff where appropriate and workplace induction. Weekly meetings to monitor agency use for Adult services, monthly for Child and Family Bed state taken into account for agency use Values based recruitment Focus on reducing current agency spend in corporate areas to zero through the Trusts efficiency programme. The Trust wide agency working group which reviews procurement, policies and adherence to the NHS I rules. longer term agency assignments will be challenged and if authorised will be monitored through Oracle to ensure the framework is used Weekly review of agency usage for community hospitals Funding for ICS is now recurrent, meaning that permanent post can be recruited to.	Financial and performance reporting Staffing and workforce reports Trust Wide Agency Working Group Monitoring against the NHS I target indicates a reduction in expenditure in targetted areas of agency spend		

CQC Links
E3: Do staff have the skills, knowledge and experience to deliver effective care and treatment?
S5: How well are potential risks to the service anticipated and planned for in advance

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Develop a workforce plan to mitigate the need for agency workers eg plan recruitment in advance based on workforce trends	Completed	*Recruitment days in place, process speeded up, will over recruit when agreed to meet future needs*	31-Mar-2016	Sally-Anne Osborne
Staff will be more confident and will be able to think of alternative strategies to support patients. This will recruit should reduce need for enhanced supervision, which will reduce current agency cost.			1-Apr-2016	Mr Steve Gregory

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Residual Risks

National shortages of some staff specialties
Supply of framework agency staff in some locations
Reduction in agency framework rates of pay create less compliance with agencies supplying staff willing to work to these.

Monitoring Group

Quality and Safety Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Ref No 1-2016 **Transformation - Local and National Contexts** **Lead** Ms Mel Duffy **Initial rating** 20 **Current rating** 15 **Target rating** 15 **Risk Indicator** ▼

Datix ID 2752 **Non Exec. Lead** Ms Mel Duffy **C x L** 5 X 4 **C x L** 5 x 3 **C x L** 5 x 3

Changes since last update Risk controls updated with latest STP position for the development of community services and outline finances, and the Trust plan

Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
WELL LED - the leadeship, management and governance of the organisation assure the delivery of high quality	RISK Local Health Economy system wide sustainability and transformation plan compromises Trust finances and services. Current plans are not sufficiently developed on community and primary care aspects. National deadlines do not reflect timescales needed to develop robust community solutions. Short term financial targets undermine transformation delivery Insufficient transition funding Individual organisational objectives compromise collaborative working Capacity to develop and deliver plans and maintain service continuity. CONSEQUENCE Current resource does not support financial/service transformation delivery. Transformation plans do not deliver expected benefits	. Key partner in Service Transformation Plan (STP) with leadership responsibility in key work-streams. . CEO and Director representation at STP Board and operational meeting. . Staff engagement in developing transformation plans to ensure they are robust and deliverable and can be costed for affordability. . Engagement with key partners. . Co-ordinated planning to ensure efficient development. . Latest STP submission includes proposals for the development of community services and outline resource requirements. . Trust 2 year operational plans are being developed to deliver the first 2 years of the STP proposals.	NON Progress reports to Board/R&P INDEP STP program director reports INDEP STP Partnership Board minutes	Trust is one partner in system plan and cannot control the full plan and its implications	

CQC Links
E1: Are people's needs assessed and care and treatment delivered in line with legislation, standards and evidence-based
R1: Are services planned and delivered to meet the needs of people?
W1: Is there a clear vision and a credible strategy to deliver good quality

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By

Residual Risks The Trust is a partner in the STP process and can influence its development but has limited control of overall planning and decision making.

Monitoring Group Resource and Performance Committee

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Risk Rating Chart

Injury/Harm	Finance	Service	Reputation	Consequence Score	Will undoubtedly occur, possibly frequently Almost certain 5	Will occur but not persistently Likely 4	May occur occasionally Possible 3	Do not expect to happen but is possible Unlikely 2	Cannot believe this will ever happen Rare 1
Likelihood Score									
Very minor or no harm	Less than £10,000	No or very little impact on services	Some negative publicity	None 1	LOW 5	LOW 4	VERY LOW 3	VERY LOW 2	VERY LOW 1
Minor injury/Illness (e.g. cuts and bruises) will resolve within a month	£10,000 to £50,000	Disruption of services causing inconvenience. May cause efficiency/ effectiveness problems	Regular negative publicity	Minor 2	MODERATE 10	MODERATE 8	LOW 6	LOW 4	VERY LOW 2
Injuries of illness which requires extra treatment or protracted period of recovery. Should resolve within a year	£50,000 to £500,000	Loss of service for a significant period of time (less that a month)	Loss of public confidence, protest action	Moderate 3	HIGH 15	MODERATE 12	MODERATE 9	LOW 6	VERY LOW 3
Single serious (life threatening) injuries/illness	£500,000 to £3.5m	Loss of services to such an extent that effects on public health will be measurable	Punitive action, e.g HSE, CQC significant organisational change results	Major 4	HIGH 20	HIGH 16	MODERATE 12	MODERATE 8	LOW 4
Multiple Serious (life threatening) injuries/illness	£3.5m plus	Permanent loss of a significant service. Threatens the viability of the organisation	Damage to such an extent that the organisation must cease to exist as is	Catastrophic 5	HIGH 25	HIGH 20	HIGH 15	MODERATE 10	LOW 5

Objective	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

Risk Register Report - Risks at Target Level — Register Level: Corporate Risk Register

Register Area — **All Directorates**

Risk ID no 956 — Risk Title: Staff Engagement — Manager Leading on the Risk: Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Not enough, or effective enough, staff engagement processes, leading to:
- Reduced quality & productivity through staff unhappiness, sickness absence & loss of motivation.
-Missed service development opportunities through staff not being aware of business potential, based on strategies & plans.
-inadequate staff understanding of EPR

Controls Currently in Place to mitigate the risk

- Engagement work over Trust values and wider culture.
- Work of Trust Leadership Group, and the Culture Working Group promoting engagement with teams.
- Workshops for administration staff.
- Awaydays for all staff
- Positive and engaged role with staff representatives. JNP meetings
- Inform, team brief and CEO staff briefings.
- Action plan to address issues raised by staff survey
- Executive/non Executive visits
- Health & wellbeing support
- Board "speed dating" with staff
- Staff involvement in shaping staff survey actions
- Staff engagement working group established for EPR

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Plan 2016 staff awaydays	Planned, taking place late 2016	Ms Jan Ditheridge	31-Jan-2017		In progress
Implement communications plan re EPR	In progress	Mr Andy Rogers	31-Mar-2017		In progress

Risk ID no 1049 — Risk Title: Clinical Negligence or Third Party Litigation — Manager Leading on the Risk: Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Group

Nature of the risk

Clinical negligence or third party claims.
Specific cases which could lead to adverse publicity or could have financial effects

Controls Currently in Place to mitigate the risk

Legal advisors
NHSLA support with claims
Low number of claims
Being Open Policy
Legal updates distributed to relevant managers

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	3	3	9
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no	1051	Risk Title	SIs, other incidents	Manager Leading on the Risk	Mr Steve Gregory

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Group

Nature of the risk

General risk associated with clinical incidents. Specific risks raised by individual incidents. Incidents leading to avoidable patient harm and insufficient learning from them.
Risk that incidents convert into complaints and claims

Controls Currently in Place to mitigate the risk

Serious Incidents monitored on Datix.
Root Cause Analysis carried out and action plans reviewed and signed off by DoN or Deputy Directors, and Commissioners;
Reports taken to appropriate committees.
RCA challenge meetings identifies trustwide solutions and communicates lessons learned
All incidents are reviewed by line managers, actions taken are detailed, field is mandatory before incident can be approved.
All incident are centrally coded and reviewed.
Staff are supported at inquests to ensure coroner is given full picture, using legal support where appropriate
Inquest report are given to Q&S committee
Quality Matters newsletter disseminates lessons learnt
Freedom to speak up assessment.
Duty of Candour arrangements and reporting
SI reporting to Executive Team

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	2	2	4
Level of Risk to be achieved	2	2	4

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no	1053	Risk Title	Training and development	Manager Leading on the Risk	Mr Steve Gregory

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Gaps in provision and take up. Potential system failures. Risk of not hitting necessary levels of mandatory training. Risk of staff not being sufficiently aware of and prepared for assessment visits by external bodies.

Controls Currently in Place to mitigate the risk

Core training model in place,reviewed annually
Central training database
Monthly monitoring of performance with recovery plans where necessary
Introduction of ESR Self Service
Annual review of mandatory training needs
HCA competency based training program
Data analysis and reporting
Competency criteria in place
Role specific essential training
Annual and ongoing review of workforce development needs commissioned from external agencies.
Integrated induction program in place

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	3	3	9

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 1054 — Risk Title: Medical Devices

Manager Leading on the Risk: Mr Steve Gregory

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Quality and Safety Group

Nature of the risk

Compliance with Safety Alerts
Financial and safety risk associated with possible inadequate and out of date register of devices
Adequacy of departmental arrangements for tracking, maintaining and disposing of devices
Compliance with MDSO notice requirements

Controls Currently in Place to mitigate the risk

Safety Alerts received by the Risk Manager and escalated to service heads via Datix which enables monitoring and reminders to be sent. Responses and actions are logged onto the system automatically
Contract with SATH Medical Engineering Services for annual maintenance
Medical Device Management Group convened to oversee processes
Medical Device Management Policy,
Verification of assets detailed by MES
Safety promoted through divisional quality and safety groups

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Raise profile of medical device management to ensure that attention is given in a measured way to all types in use	Medical devices discussed at Divisional Quality and Safety meetings		31-Dec-2015	30-Jun-2016	Completed

Risk ID no 1056 — Risk Title: Safeguarding, including thresholds for referral

Manager Leading on the Risk: Dr Mahadeva Ganesh

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Quality and Safety Committee

Nature of the risk

Risk of compliance with law in relation to childrens and adult safeguarding.
Specific risks relating to incidents, concern or gaps in provision

Controls Currently in Place to mitigate the risk

Safeguarding Leads identified for Children.
Deputy Director of Nursing and Quality - Operational and management lead for safeguarding.
Trust safeguarding meetings established.
Safeguarding reported to Quality and Safety Committee.
Executive Lead member on the two Local Authority Adults and Children Safeguarding Boards.
Six monthly Section 11 audits
Compliance with Safeguarding Self Assessment Tool
Mandatory training for staff
Compliance with CQC principles

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 1438 **Risk Title** Compliance with data protection legislation **Manager Leading on the Risk** Ms Ros Preen

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

None compliance with Data protection could lead to action by the Information Commissioner. The level of fines has increased recently with a number of NHS organisations being fined.

Controls Currently in Place to mitigate the risk

Information governance policies
Incident reporting and investigation
IG training mandatory for all staff
Provision of advice and support
Records audit.
Networking with IG leads to learn lessons across all public sector organisations.
Compliance with IG toolkit

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	3	3	9

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 1995 **Risk Title** Transformation - Staff **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

RISKS
Trust does not develop staff skills to meet increased care complexity in community settings.
Trust cannot recruit staff with additional clinical skills.

CONSEQUENCES
Additional services cannot be provided on homecare setting to meet transformation needs.

Controls Currently in Place to mitigate the risk

Forward workforce planning.
Dialogue with commissioners and other providers identifying service change and associated skilling necessary.
Workforce monitoring via ODW group
OD strategy and workplan.
Quality Strategy.
Nursing and AHP Strategy
Training statistic monitoring and actions
Role specific essential training in place
Values into Action program

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 2000 **Risk Title** Data Quality **Manager Leading on the Risk** Ms Ros Preen

Where the risk applies to

Nature of the risk

Controls Currently in Place to mitigate the risk

Division	All Directorates
Area/Division	
Service	Administration Areas
Monitoring Group	Resource and Performance Committee

RISK
Data relating to Trust performance is inaccurate or is not available in a timely way.
Concerns relate to clinical activity data and some HR data.
Information collected in several systems leading to collation problems.

CONSEQUENCE
Inadequate information to support decision making.
Inaccurate costings.
Not being able to demonstrate accurately compliance with performance targets.
Potential risks to income.

Information collation into data warehouse.
Validation of data by informatics and operations managers.
Data quality indicators on all metrics on the performance report.
In phase software for performance reporting.
Data cleansing on waiting times to ensure accuracy for non RTT services.
Reduced target timescale for data capture.
Performance Management Framework developed to provide greater focus on metrics.

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Review timescale for data entry across operations		Mrs Tessa Norris	31-Jul-2014	31-Jul-2014	Completed
Implement recommendations from the internal audit of data quality.		Trish Donovan	31-Jul-2014	31-Jul-2014	Completed
Implement and embed In Phase software for performance reporting across all areas	Underway	Lee Osbourne	31-Dec-2014	31-Dec-2014	Completed
Deliver data quality improvement plan	Elements of data quality audit have been reviewed and those relating to system operating procedures will be addressed through the EPR project.	Lee Osbourne	31-Dec-2014	31-Dec-2014	Completed
Implement Performance Management Framework	PMF now rolled out across clinical services and corporate functions	Ms Ros Preen	31-Dec-2015	30-Apr-2015	Completed

Risk ID no **2493** **Risk Title** **Lone working** **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division	All Directorates
Area/Division	
Service	
Monitoring Group	Quality and Safety Group

Nature of the risk

Risk associated with lone working:
Staff Safety
Road safety
Professional issues
Safety issues e.g. handling patients single handed

Controls Currently in Place to mitigate the risk

Lone working section in Violence Policy
Local assessment of particular risks with services
Local procedures, include staff whereabouts and personal details
All community staff have mobile phones
Lone worker staff survey
Audit of checking arrangements
Audit of local procedures

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	3	9
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 2494 **Risk Title** Estates issues **Manager Leading on the Risk** Ms Mel Duffy

Where the risk applies to

Division All Directorates

Area/Division

Service

Monitoring Group Quality and Safety Group

Nature of the risk

Estates issues can take a protracted period of time to resolve. A number of issues have remained on divisional register for a long period, e.g. Hospital laundry's, washbasins and dental hoist.

Controls Currently in Place to mitigate the risk

Regular review of registers
Escalation of risks

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	3	3	9

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Review estates function to ensure that Trust is receiving the best service and value for money		Ms Mel Duffy	31-Dec-2016		In progress
Set up a central estates helpdesk with SSSFT to cover all properties and to enable monitoring of job completion and response times. Job requests will include an analysis of the risk to enable prioritisation.			31-Dec-2016		In progress

Register Area **All Directorates**

Risk ID no 325 **Risk Title** Business Interuption **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Quality and Safety Committee

Nature of the risk

Robust business continuity plans are necessary to ensure that should either foreseen or unforeseen circumstance occur which compromise services then rehearsed and documented plans can be quickly initiated to manage the safety of these services. Some realignment is necessary of existing plans to fit in to the new organisational structures.
Example of circumstances are:
Adverse weather conditions
Fuel Shortages
Illness (e.g. flu pandemic)
Industrial Action
Heatwave
There are particular issues with snow and ice, and getting to remote community locations

Controls Currently in Place to mitigate the risk

Individual business continuity service plans
Corporate business continuity plan
Heatwave plans
DoH, TDA and NHSE guidance
Dedicated support for emergency planning and business continuity
Regular exercise to test plans and review.
Review of plans following incidents
Annual review of Business Continuity Plans
Multi agency register of localised risks
Health Economy Planning for peaks in demand

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	4	3	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	2	3	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Establish regular BCM manager forum.	Completed	Pete Old	31-Dec-2015	12-May-2016	Completed
Specific plans need to be developed for total evacuation procedure and lockdown These relate in the main to hosptials	Work is progressing on plans, challenges due to building layout and structure have been challenging leading to change is completion date. Timeline agreed to complete and test, October 2016.	Pete Old	31-Oct-2016		In progress

Risk ID no 966 **Risk Title** Community links and Reputation **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Board

Nature of the risk

Community links not sufficiently strong or consistent across the area, leading to low awareness of Trust or poor reputation, as a result of:

- Limited capacity in-house.
- Insufficient awareness in house.
- Competing interests for public/communities e.g. acute services issues

Controls Currently in Place to mitigate the risk

- Patient and Carer Panel in place
- Meetings with wide range of stakeholders; media work; staff engagement
-Stakeholder engagement events
- Publishing of key information on Trust website
- Board members and exec team regularly meet staff and patients on informal visits.
- strong contact with Leagues of Friends.
- non execs as named links with stakeholders

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	2	3	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Risk ID no 1046 **Risk Title** Policies **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Quality and Safety Group

Nature of the risk

Risk of lack of staff awareness and compliance with policies, failure of organisation to keep policies up to date
Gaps in provision of policies

Controls Currently in Place to mitigate the risk

Policies are published on the staff Internet. Site has been updated so that staff can more easily search for relevant policies.
Formal distribution via Datix alerting system to all senior personnel. Response required for assurance that policies have been actioned
Policy on procedural documents sets out process for development and approval of polices.
Reminders sent to authors monthly, with a summary report to Directors detailing policies overdue for review, and policies due for review in next 6 months
Reports to Quality and Safety Committee and Execs meeting with deputies.

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	5	15
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	1	3

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Agree additional arrangements for progress reports to executive team and Quality and Safety Committee	System has been implemented	Peter Foord	30-Apr-2016	3-May-2016	Completed

Risk ID no 1047 **Risk Title** Risk Management **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division All Directorates
Area/Division Administration
Service Administration
Monitoring Group Audit Committee

Nature of the risk

Lack of awareness of risks or lack of understanding of staff of how to report and manage risks leading to harm.
Failing to ensure that risks are identified and mitigated, and that risks are escalated appropriately

Controls Currently in Place to mitigate the risk

Risk management training is part of managers mandatory training program
Awareness raising in 'Inform' and Team Brief.
Directorate registers
Reporting to Audit Committee
Risk Register working group reporting to Q&S Operational Group
Risk Management Policy in place.
Risks discussed at Performance Review Meetings.

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	5	15
Current Level of the Risk	3	3	9
Level of Risk to be achieved	2	3	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Further risk forum to include effective escalation	Currently working with individual managers and team leaders to improve risk management through risk assessment and team leaders. to consider forum later in the year	Peter Foord	30-Dec-2016		In progress
Further actions needed based on CQC feedback	Main area is to encourage incident reporting, particularly in outlying areas and further develop culture supportive of reporting risk. Address consistency of risk reporting in specific areas, especially MIUs. Ensure the end of life care risks are identified and actioned.	Peter Foord	30-Dec-2016		In progress

Risk ID no 1048 **Risk Title** Health & Safety Legislation **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Group

Nature of the risk

Compliance with Health and Safety, Food, Waste and Environmental Legislation

Controls Currently in Place to mitigate the risk

Staff and managers awareness of requirements through training and publicity
Support from Risk Manager
Incident reporting to highlight issues
SLA with estates for support for food, waste and environment operational activities
Policies in place or adopted
Professional support available for HS, Estates, Security and Infection Control

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	5	20
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	1	3

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Qualitative audit of risk assessments to be completed and fed back to risk leads	Meeting with CSMs and Team leaders to give feedback on H&S/risk management to improve consistency with risk management. To be completed by end Feb 16	Peter Foord	29-Feb-2016	16-Mar-2016	Completed

Risk ID no	1147	Risk Title	Staff Sickness	Manager Leading on the Risk	Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Long term sickness trend reducing but short term slightly increased. Areas of especially high sickness at times with potential for reduced quality and increased agency use.

Controls Currently in Place to mitigate the risk

Performance management arrangements.
Attendance management policy
Monitoring of monthly statistics and identification of hot spots and support by HR team for these areas
Focussed attention by operational divisions.
Health and wellbeing strategy.
Physiotherapy referral scheme for MSK problems
Stress Policy.
Manager training on management of sickness absence
QS Committee Monitor progress and deep dive where indicated
Targeted action to address areas of concern
Improved flu vaccine take up

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	5	15
Current Level of the Risk	3	4	12
Level of Risk to be achieved	3	3	9

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Refresh Health and Wellbeing Strategy	Complete	Clare Guerreiro	31-Jul-2016	21-Sep-2016	Completed
Strengthen and formalize recovery plans	Complete.	Ms Julie Thornby	30-Sep-2016	17-Oct-2016	Completed
Further analyse and triangulate causes	Underway	Sara Hayes	30-Nov-2016		In progress

Risk ID no	1223	Risk Title	Board Leadership	Manager Leading on the Risk	Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Board

Nature of the risk

Board does not assure an effective organisation with high quality, well-led services.

Controls Currently in Place to mitigate the risk

Board development programme
External and Internal Board and Committee evaluation
Board member appraisals
Board engagement with staff and stakeholders
Board involvement in strategy
Board and Committee workplans
Governance structures
Internal audits of governance

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	3	2	6
Level of Risk to be achieved	2	2	4

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Actions in response to CQC reports (more robust assurance and understanding of risk management).	Underway	Ms Julie Thornby	31-Jan-2017		In progress
Review self-assessment on "well-led".	Planned.	Ms Julie Thornby	28-Feb-2017		In progress

Risk ID no 1571 **Risk Title** Waiting Times **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Resource and Performance Committee

Nature of the risk

Waiting times do not meet local or national targets
There are particular problems with the recording data at an operational level
Particular problem with TEMS, which has now improved

Controls Currently in Place to mitigate the risk

Regular reporting of performance.
Production of recovery plans as problems arise to address where waiting time exceed acceptable parameter.
Data validation each month
Working with commissioners to develop plans to address issues in longer term.
Weekly validation report to service as part of monthly reporting.
Implemtation of new access control policy (November 16)

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	2	4	8
Level of Risk to be achieved	2	3	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Implement recommendations made by internal audit	Responses on progress being collated. Operations actions updated 3rd August 2016.	Mr Andy Matthews	30-Sep-2016		In progress

Risk ID no 1717 **Risk Title** Staff Appraisals **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Staff do not perceive appraisals as high quality and helpful leading to:

Reduced staff motivation and contribution to Trust aims.
Lack of assurance that staff are competent to undertake their role
Staff dissatisfaction and engagement reduction
Lack of confidence from Regulators

Controls Currently in Place to mitigate the risk

Training on appraisal process.
Reports through Monthly Performance Report and discussions at relevant meetings
Simplification of appraisal paperwork and process, after staff engagement, New system now established across Trust
Recovery plans

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	4	12
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Increase target and include bank staff	In progress	Mr Steve Gregory	31-Mar-2017		In progress

Risk ID no 2258 **Risk Title** Compliance with Equality Requirements **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Nature of the risk

Controls Currently in Place to mitigate the risk

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

RISK
Trust does not meet needs of people in protected characteristics group, and they have poorer access to, experience of, Trust services.
Trust does not promote equality and allows direct or indirect discrimination leading to patient or staff disadvantage, possible loss of Trust reputation and claims.

Everyone Counts working group and three operational leads in place
Equality Delivery System 2 completed
Operational leads identifying good practice and gaps
Equalities sub group of patient panel
Information required by legislation is published
Quality and Equality Impact Assessments for service developments.
Two Tick disability accreditation for HR processes
Equality Policy refreshed2015
Mandatory training

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	2	4	8
Current Level of the Risk	2	4	8
Level of Risk to be achieved	2	2	4

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Progress EDS2 and Race Equality Standard	EDS2 assessment completed	Ms Julie Thornby	31-Mar-2016	16-May-2016	Completed
Run 'PLACE' type assessments from equality view.	Underway	Mr Mark Donovan	31-Mar-2017		In progress

Risk ID no 2316 Risk Title Estates Compliance Issues Manager Leading on the Risk Ms Mel Duffy

Where the risk applies to

Division	All Directorates
Area/Division	Estates
Service	Estates Management
Monitoring Group	Resource and Performance Committee

Nature of the risk

Asbestos surveys have not been recently carried , and require asbestos management plans to be put into place.
Risk to contractor and staff if regular inspection is not carried out
Lack of assurance from the Estates contractor on other compliance issues, e.g. electrical testing, water testing
Fire risk assessment not in place for all buildings

Controls Currently in Place to mitigate the risk

Asbestos policy was updated October 2014
Sites being reviewed by contractor
Assurances are being received from the contractor.
Scoping and assessing against NHS premises assurance model.
Program in place to inspect all buildings that are the Trust responsibilities and were constructed pre 2000.
Significant progress made with 5 year electrical testing and legionella control maintenance.
Fire stopping survey completed and inspection regime established.
Fire advisor in place

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	2	6
Level of Risk to be achieved	3	1	3

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Commission and complete asbestos surveys and complete remedial works for Trust owned properties	Surveys underway, Asbestos containing materials are being encapsulated or removed at Bridgnorth, Ludlow and Whitchurch Community Hospitals 15 out of 18 assessments have been carried out. Ludlow is the responsibility of NHSPS. SCHT will commission the survey to ensure that it is completed.	Ms Mel Duffy	31-Jul-2016	31-Jul-2016	Completed
Liaise with contractor to establish position for all estates compliance issues and action where gaps are identified.	Substantial work for water and electrical testing has been carried out. Completion date carried forward to November 2016	Ms Mel Duffy	30-Nov-2016		In progress
Audit fire risk assessments and actions, create a register. Carry out assessment where necessary	21 assessments have taken place, with actions being allocated to appropriate departments. Date carried forward to November 2016 for verification of completion	Steve Lloyd	30-Nov-2016		In progress

Risk ID no 2492 Risk Title Blood Glucose **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division All Directorates

Area/Division

Service

Monitoring Group Quality and Safety Group

Nature of the risk

Trust has in the past obtained blood glucose test strips, meters and Quality Assurance Solution as part of Acute contract. Acute has transferred to a different system. Previous supplier has maintained stock on a goodwill basis. Trust needs to have a contract in place. There are challenges with storage, distribution and other aspect of management, and additional costs are likely to be identified

Controls Currently in Place to mitigate the risk

Regular contact and meetings with previous supplier
Survey of practice and recommendations made where improvements are needed
Involvement of procurement

How the Risk is Rated

	Cons	Like	Rating
Level of Risk with no control	3	3	9
Current Level of the Risk	3	3	9
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Work with purchasing and managers to put into place a new contract for BM strips, QA solution and meters.	Contract to be signed Aug16, implementation Sept to Dec	Mrs Angela Cook	30-Dec-2016		On track

Risk ID no 2495 **Risk Title** Recruitment **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

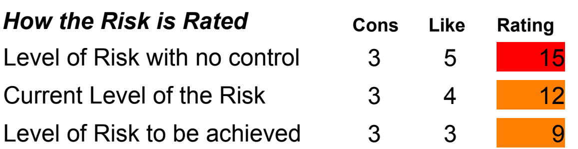
Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Recruitment issues regularly feature on divisional registers. These can come from national or local shortages, time taken to place staff, or where disciplines have only one post. These have included:
Prison
Diabetes Nursing
Community Neuro Rehab
CAMHS
Dental

Controls Currently in Place to mitigate the risk

Contingency and prioritisation
Recruitment initiatives e.g. open days, work with universities, rotational posts.



How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	5	15
Current Level of the Risk	3	4	12
Level of Risk to be achieved	3	3	9

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Actions are covered within the agency use entry					In progress

Risk ID no 2738 **Risk Title** Introduction of the new Apprentice Levy **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

A levy is to be introduced from 2017 for medium and large organizations (pay bill of over 3m). Levy is 0.5%. If the trust fails to attract apprentices then the levy will be paid without benefit. Public sector target to be met (not currently set)

Controls Currently in Place to mitigate the risk

Increasing awareness of levy and apprenticeships
Looking at current employees to identify existing staff who may be eligible
Manager to review vacancies.
Internal targets set and monitored at HR Group and Execs
Meeting with deputies.

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	3	9
Current Level of the Risk	3	3	9
Level of Risk to be achieved	3	2	6

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Review of progress at year end.		Sara Hayes	31-Mar-2017		In progress

Risk ID no 2770 **Risk Title** Non compliance with annual leave policy **Manager Leading on the Risk** Ms Julie Thornby

Where the risk applies to

Division	All Directorates
Area/Division	Administration
Service	Administration
Monitoring Group	Quality and Safety Committee

Nature of the risk

Failure to comply with annual leave policy, so that principles about how many staff can take leave in any team or area at one time are not complied with,or individuals' leave is not distributed through the year, leading to avoidable peaks of annual leave resulting in pressures on service delivery and on costs and quality via demand for temporary staffing.

Controls Currently in Place to mitigate the risk

Initial audit to determine extent and scope of issues
Addition of annual leave to ESR system so compliance can be monitored on an ongoing basis
Trust-wide manager application of annual leave policy

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	4	4	16
Current Level of the Risk	3	3	9
Level of Risk to be achieved	2	2	4

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status
Audit of policy compliance.	In progress	Mr John Snell	30-Nov-2016		In progress
Implementation of annual leave on ESR	In progress	Mr John Snell	31-Mar-2017		In progress

Risk ID no **2775** **Risk Title** **Leadership skills/Supervision** **Manager Leading on the Risk** Mr Steve Gregory

Where the risk applies to

Division All Directorates

Area/Division Administration

Service Administration

Monitoring Group Quality and Safety Committee

Nature of the risk

Leadership skills are variable across the Trust. This affects supervision,communication and can affect staff morale, care effectiveness and workload.
Clinical supervision in some areas is sporadic. This affects staff development and impacts on clinical effectiveness.

Controls Currently in Place to mitigate the risk

Managers mandatory training program. Includes HR, finance and safety
CTLG meetings for managers to ensure conformity with trust values
Culture Working Group and action plan.
Human factors group

How the Risk is Rated	Cons	Like	Rating
Level of Risk with no control	3	4	12
Current Level of the Risk	3	3	9
Level of Risk to be achieved	2	2	4

Additional controls and actions required to mitigate the risk

Description	Progress	Who is responsible	Due date	Date Done	Status

Appendix 3

Hospitality Register: 1 June 2015 to 1 August 2016

Summary of Hospitality Register

Below is a summary, by Directorate, of each entry received for the Hospitality Register between 1 June 2015 – 1 August 2016 detailing offers which were accepted. There have been no notifications of offers of sponsorship/gifts etc which were made but not accepted. Each entry is submitted for review and sign off by the individual's manager, and then by the Director of Corporate Affairs before being entered in the Register.

This year as last, there have been a number of declarations from our diabetes team relating to pharmaceutical companies. The Committee asked for additional assurance on this last year, and the Chief Pharmacist was asked to review it. Her review of the team's prescribing indicated no patterns to suggest particular influence in favour of the sponsoring companies.

Operations Directorate

Date and Amount of Hospitality, Gift or Sponsorship	From	To	For (plus any additional comments by recipients)	Date of Register Proforma
21.5.15	Astra Zeneca	Cassandra Ricchiviti. Diabetes Dietician	Study Day at Diabesity - Birmingham	21.7.15
08.1.16 £500	Eli Lilly	Diabetes Nursing Service	Education event for DSN Team "High performing Teams" Development day	18.1.16
22.9.15 £350	Barry Jones Noro Nordisk	Rebecca Lennon/Angela Cook, Diabetes Nursing Service	Sponsorship Warwick Diabetes course	18.1.16
17.11.15 £350	Eli Lilly	Rebecca Lennon/Angela Cook, Diabetes Nursing Service	Sponsorship for Warwick Diabetes course	18.1.16
20.10.15 £350	Sanofi	Rebecca Lennon/Angela Cook, Diabetes Nursing Service	Sponsorship Warwick Diabetes course	18.1.16
25.11.15 and 26.11.15 £440	Ontex	Andrea Davis, Community Nurse	Sponsorship of 2 places at RCN Continence Core Forum/Conference and exhibition	2.12.15
15.12.15 £350	Eli Lilly	Rebecca Lennon/Angela Cook, Diabetes Nursing Service	Sponsorship Warwick Diabetes course	18.1.16
19.1.16 £350	Astra Zeneca	Rebecca Lennon/Angela Cook, Diabetes Nursing Service	Sponsorship Warwick Diabetes course	3.2.16

16.2.16 £350	Abbott	Rebecca Lennon/ Angela Cook Diabetes Nursing Service	Lunch, coffees, stand at course and information for delegates	5.4.16
29.4.16 £10	Lloyds Pharmacy	Emma Humphries, Community Health Services Pharmacist	Lunch provided during the course of working visit	10.5.16
27.4.16 £10	Lloyds Pharmacy	David Young, Lead Pharmacist for Community Hospitals	Lunch provided during the course of working visit	10.5.16
29.4.16 £10	Lloyds Pharmacy	Rita O'Brien Chief Pharmacist	Lunch provided during the course of working visit	10.5.16
23.06.16 £40	Breathe Easy Telford	Elsa Davies, Respiratory Team Leader	Marks and Spencer Vouchers. This was presented as a leaving gift by a patient group. The value exceeds what should be accepted under our Code; this was highlighted to the line manager for future reference.	01.08.16
14.7.16 £20	Parent of patient	Maureen Chappell, CBT Therapist	2 tickets for theatre, patient appearing in production there.	10.08.16

Trust Board

Date and Amount of Hospitality, Gift or Sponsorship	From	To	For (plus any additional comments by recipients)	Date of Register Proforma
05.06.15 and 06.06.15 £350.00	Emap Publishing Ltd/HSJ	Jan Ditheridge Chief Executive	Attendance at HSJ Summit. Complimentary place to include overnight accommodation	11.11.15
17.5.16 And 18.5.16 £2000	AH Media Ltd	Dr Mahadeva Ganesh, Medical Director	To attend Healthcare Strategy Forum, 2 complimentary passes to include seminars, hotel, meals and refreshments	4.3.16
15.06.16 £35	Mills and Reeve	Jan Ditheridge Chief Executive	Pre-dinner Drinks and dinner at NHS Confed Conference ass guest of Mills and Reeve at Rosso Restaurant, Manchester	06.07.16
15.06.16 £35	Mills and Reeve	Mike Ridley Chairman	Pre-dinner Drinks and dinner at NHS Confed Conference ass guest of Mills and Reeve at Rosso Restaurant, Manchester	29.07.16

15.06.16 £20	PWC	Mike Ridley Chairman	Drinks and canapes as part of the NHS Confed Conference	29.07.16

Corporate Affairs Directorate

None

Finance Directorate

None

Nursing Directorate

None

Medical Directorate

None

Appendix 4

Audit Committee

Annual Report 2015/16

1. Introduction

NHS Trusts are required to have an Audit Committee under the Codes of Conduct and Accountability issued by the Department of Health in 1994, and re-issued in 2004. For Foundation Trusts the requirement is set out in Monitor's Code of Governance. The purpose of the Committee is to obtain assurance that risk controls work as designed, and to challenge poor sources of assurance. In particular this work applies to the controls and assurance required to manage risks to the organisational objectives. These risks are set out in the Board Assurance Framework.

Guidance on the operation of Audit Committees is set out in the Audit Committee Handbook, originally published by the Department of Health in 2005, updated by the Healthcare Financial Management Association in 2010 and 2014. This guidance highlights the importance of producing an annual report detailing how the Committee has met its duties.

This document is the Annual Report for 2015/16. The opinions on internal control expressed by Internal and External Audit apply to the financial year 2014/15. These were given in June 2015. Other aspects in the report will include the period April to September 2015 where it is appropriate to do so.

2. The Role and Operation of the Audit Committee

The Committee consists of three Non-Executive Directors:

- Peter Phillips (Chairman)
- Nuala O'Kane
- Steve Jones

Mrs O'Kane and Mr Jones joined the committee from the October 2015 meeting.

For the April, June and July 2015 meetings the committee consisted of Peter Phillips, Angela Saganowska and Mike Sommers.

From July 2016 Rolf Levesley became a member of the Committee, bringing the membership to four.

- Mr Phillips and Mr Jones have financial expertise.
- All other Non Executive Directors (excluding the Chairman) can attend any meeting if they wish.
- Rolf Levesley (Non-Executive Director) has attended on a regular basis throughout the year, before becoming a formal member in July 2016.

The Committee is supported by the following co-opted members:

- Director of Corporate Affairs
- Director of Finance
- Corporate Risk Manager
- Representative from External Audit
- Representative from Internal Audit

The Local Counter Fraud Specialist attends on a regular basis to report on their work.

Other managers and subject experts attend at the request of the committee.

2.1 Record of Attendance

	Meeting					
Members	**9/4/15**	**2/6/15***	**29/6/15**	**6/10/15**	**5/1/16**	**% attendance**
Peter Phillips	✓	✓	✓	✓	✓	100
Nuala O’Kane				✓	✓	100
Steve Jones				✓	✓	100
Rolf Levesley	x	x	✓	x	✓	N/A
Angela Saganowska	✓	✓	✓			100
Mike Sommers	✓	✓	✓			100
Supporting members						
Director of Corporate Affairs	✓	x	✓	✓	✓	80
Director of Finance	x	✓	✓	✓	✓	80
Corporate Risk Manager	✓	✓	✓	✓	✓	100
Local Counter Fraud Specialist	x	x	✓	x	✓	N/A
Representative from External Audit	✓	✓	✓	✓	✓	100
Representative from Internal Audit	✓	Not required	✓	✓	✓	100

*Extraordinary meeting to approve the annual account

All meetings were quorate.

2.2 Committee Work Programme/ Plan

The committee has a rolling programme of work, detailing what reports will come to the committee and when.

The key aspects of the work plan are detailed in this report, split into the following areas:

- Principal review areas detailed in the work plan
- Internal Audit
- External Audit
- Management
- Financial Management

2.3 Auditor Panel

In January 2016 the Board nominated the Audit Committee as the Auditor Panel. The Panel consists of the same membership as the Committee. The panel will oversee the tendering of External Audit Services, and will evaluate the tenders and make recommendations to the Board. External Audit Services must be selected by December 2016. The panel meets separately from the Committee.

The Audit Committee Terms of Reference have been updated and agreed by the Board to reflect these arrangements.

3. Main risk management areas reviewed by the Committee

The principal review areas are set out below:

3.1 Board Assurance Framework.

The Audit Committee reviews the Board Assurance Framework at each meeting. The review considers what assurances the committee has received, whether additional assurance is needed and whether the risks detailed represent the principal risks to the organisational objectives. From June 2015 the committee received an assurance profile for each risk. This includes the expected sources of assurance, any updates in these assurances and any additional assurances. These are RAG rated e.g. Green equals positive assurance. The committee considered risk appetite throughout the year, and concluded that this should be considered separately in each case dependent on the subject.

Throughout the year there have been 8 entries on the Board Assurance Framework (BAF). One entry for Fire Safety arrangements was transferred from the BAF to the Corporate Register in January 2016. The entries were:

Meeting Financial Targets

The major assurances received for financial systems have been from internal auditors. These relate to financial systems and have provided either substantial or good assurance. The unqualified opinion given by external auditors confirms that the risks associated with finance are well managed. The committee recognised that there are ongoing challenges, particularly with cost improvements, and that the level of risk is likely to change. The committee approved the Trust's Accounting Policies and the report on Going Concern.

Transformation Local and National Contexts

The committee receives assurances from the Resource and Performance Committee related to this entry. At the beginning of the year there were concerns that Future Fit may affect the level of risk. The current level of risk was increased from a score of 6 to 12 in May 2015. The growing emphasis on ensuring robust community services in the context of 'Community Fit' and latterly the Sustainability and Transformation Plan (STP) has provided assurance related to the impact. The risk has been substantially updated for the October 2016 meeting.

Transformation (Systems)

The main risk currently associated with this entry is the introduction of the EPR. Assurance related to this is given by the EPR Project Group to Resources and Performance Committee. The Audit Committee has not reviewed any other assurances.

Recruitment/Agency Costs

The committee has noted that the situation has improved, but that it remains a significant risk which presents a significant challenge to meeting financial targets.

Trust Sustainability

The risk links to the entry for transformation, and to the development of new community models of care in relation to Community Fit and the STP . The committee requested, and received, further assurance related to the development and process for strategic direction.

Clinical Quality

The committee receives reports and assurances related to clinical governance systems, detailed in 3.3. In addition to these the committee reviews service risks registers, which give an overview of service clinical quality and safety risk. The committee can request additional reports of assurances where if feels necessary. No additional assurances have been requested.

Changing Culture

The committee reviewed the risk in detail at its June meeting. The risk, consequences and controls were amended and the risk rating reduced. The assurances are noted as HR statistics and staff surveys. The Quality and Safety Committee receives assurances related to these which the committee receives via meeting minutes and the External and Regulatory Report from the committee.

3.2. Internal Control Systems

The committee receives the Corporate Risk Register at each meeting, and the Divisional/Directorate Registers on a rolling programme. This gives the committee an overview of the risks on the registers, the opportunity to consider individual risks, and more importantly an overview of the risk management system.

3.3 Clinical Quality

The committee does not consider individual quality issues, but does seek assurance on the systems of internal control used in the management of quality. The committee considered Clinical Audit Reports, processes for identifying CQC compliance, summaries of reports received by the Quality and Safety Committee, as well as receiving the minutes of the Quality and Safety Committee.

4. Internal Audit

The Committee has worked effectively with Internal Audit to scrutinise and improve the Trust's systems of internal control. At each meeting the committee receives a comprehensive progress report against the annual audit plan which includes progress made against recommendations.

The following reports were received in 2015/16.

Audit	Assurance	Rating
Cost Improvement Programme – Quality Impact Assessment Process	Partial	No rating
Validation of reported closed high and medium priority recommendations	38% implemented	
Validation of reported closed high and medium priority recommendations	Advisory	
Transformation Governance Arrangements (Focus on Integrated Community Service)	Advisory	
Information Governance Toolkit	Advisory	
Lease Car - Authorisation Process	No Assurance	
Data Quality – Referral to Treatment (Incomplete Pathways)	No Assurance	
Ward Staffing – Recording and Data Quality	Partial	
Absence Management- Compliance with the Trust Policy	Partial	
Doctor Revalidation and Appraisal Process	Reasonable	
Budgetary Reporting	Reasonable	
Electronic Expenses Reimbursement	Reasonable	
Care Quality Commission –Mock Inspections	Reasonable	
Payroll	Reasonable	
Recruitment and Selection- Compliance with Trust Policy	Reasonable	
Procurement Savings	Substantial	
IT Key Financial Systems Review	Substantial	
Assurance Framework and Risk Management	Substantial	
General Ledger	Substantial	

Key Financial Systems- Creditors, Debtors, Cash and Asset Management	Substantial	
Charitable Funds Committee and Ward Administration at Bridgnorth Community	Substantial	

The Committee received and considered the above reports. The management responses provided assurance that any actions identified have been, or are being implemented. The Head of Internal Audit Opinion and Annual Governance Statement reflect the findings of the reports, that significant assurance can be given that there is a generally sound system of internal control. The Committee received and approved the Internal Audit plan for 2015/16 at its April meeting.

5. External Audit

The Committee received the External Audit Annual Findings Report at its meeting on the 27th May 2016. The external auditors were required to give an opinion on the financial statement and a Value for Money (VFM) assessment. An unqualified opinion was given for the financial statements, that proper arrangements are in place to secure financial resilience and proper arrangements are in place for challenging how the Trust secures economy, efficiency and effectiveness.

External Auditors have not carried out any non-audit work for the Trust.

6. Management

As part of its review of the BAF, other risk registers and control/risk management systems, the Committee has requested additional information and reports from Trust management and other sources to obtain relevant assurance where necessary. This has included in the last year:

- Community Hospital Emergency Evacuation and Lockdown procedures
- Service Line Reporting
- Service Level Agreement management
- Links between Clinical Audit and Risk Registers
- Staff Appraisal

The committee reviews the Annual Governance Statement, taking into account the information and assurances it has received throughout the year. The statement is an integral part of the annual reporting processes.

7. Financial Management

The Committee received and approved the financial statements at its extraordinary meeting in May 2016, prior to submission to the NHS Improvement. It praised the significant work carried out by the finance department both in producing the annual accounts and operating sound financial systems throughout the year. The Committee received the reports from Internal and External Audit relating to the accounts. The Committee was satisfied that the reports can be considered accurate. The Committee reviewed and approved the Annual Report to ensure that it accurately reflected the years' events.

8. Review of the effectiveness and impact of the Audit Committee

The Committee has during the year carried out its duty in providing the Board with assurance that effective internal control arrangements are in place. Specifically the Committee has:

- Reviewed the Assurance Framework and Risk Registers and has influenced the development processes of the risk management system through the Risk Management

Policy.. Internal Audit provided positive reports on the development of risk management processes of the Trust, and on the operation of the BAF.

- Reviewed its compliance with the Audit Committee Handbook and has undertaken a self assessment. This assessment is appended to this report.

9. Conclusion

The Committee has concluded that overall the Trust has a sound system of internal control, and that when inadequacies are identified, action is taken to improve systems. This view has been confirmed by the opinions of External and Internal Audit. The Committee has not identified any issues that have not been disclosed to the Board appropriately. The committee has not identified any areas of duplication or omission in the systems of internal control, or of governance in general.

Audit Committee
SELF-ASSESSMENT CHECKLIST

Checklist One: Committee Processes

	Area/Question	Y	N	Comments/Action
1	**Composition, establishment and duties**			
1a	Does the Audit Committee have written terms of reference that adequately define the Committee's role in accordance with relevant guidance (for example; from Department of Health; NHS England; NHS Trust Development Authority or Monitor)?	Y		Updated April 2016 to include Auditor Panel responsibilities
1b	Have the terms of reference been adopted by the governing body?	Y		All changes are approved by the Board.
1c	Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Y		Terms of reference are reviewed annually
1d	Are committee members independent of the management team?	Y		Members are Non-Executive Directors. Management team attend to provide information and support..
1e	Are the outcomes of each meeting; the actions taken and the committee's view on the organisation's systems of internal control reported to the next governing body meeting?	Y		A report is prepared after each meeting as part of the Governance Report to the Board
1f	Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the governing body?	Y		
1g	Does the committee assess its own effectiveness periodically?	Y		Via this checklist
1h	Has the committee established a plan of matters to be dealt with across the year?	Y		A work plan is in place, reviewed at each meeting, supported by an Internal and External audit plan
1j	Are committee papers distributed in sufficient time for members to give them due consideration?	Y		One week beforehand
1k	Has the committee been quorate for each meeting this year?	Y		
2	**Compliance with the law and regulations governing the NHS**			
2a	Does the committee review assurance and regulatory compliance reporting processes?	Y		Via internal and external audit, and from other reports e.g. Regulatory report from QS Committee
2b	Does the committee have a mechanism to	Y		Emerging issues from internal

	keep it aware of topical, legal and regulatory issues?			and external auditors, and from executive directors
3	**Internal control and risk management**			
3a	Has the committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management, quality and clinical governance committees?	Y		Relationship with Quality and Safety Committee established, with minutes coming to each meeting. There is also links to other Board sub-committees though the membership of the Audit Committee.
3b	Has the committee reviewed the robustness and effectiveness of the content of the organisation's assurance framework?	Y		At each meeting, and via Internal Audit scrutiny.
3c	Has the committee reviewed the robustness and content of the draft annual governance statement before it is presented the governing body?	Y		Both in development and prior to signing
3d	Is the committee's role in reviewing and recommending to the governing body the annual report and accounts clearly defined?	Y		Covered in the terms of reference and discussed at the meeting as issues arise
3e	Does the committee consider the external auditor's report to those charged with governance including proposed adjustments to the accounts?	Y		Yes, at the June extraordinary meeting,
4	**Internal audit**			
4a	Is there a formal 'charter' or terms of reference, defining internal audit's objectives, responsibilities and reporting lines?	Y		Internal Audit Charter signed by the committee chair and agreed by members .
4b	Does the committee review and approve the internal audit plan at the beginning of the financial year?	Y		
4c	Does the committee approve any material changes to the plan?	Y		The committee approves any changes as part of progress report monitoring.
4d	Is the committee confident that the audit plan is derived from a clear risk assessment process that links closely to the assurance framework?	Y		Links are detailed on the plan
4e	Does the committee receive periodic progress reports from the Head of Internal Audit?	Y		At each meeting
4f	Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	Y		Via IA audit tracking report local reporting
4g	Does the Head of Internal Audit have a right of access to the committee and its Chairman at any time?	Y		And via the auditor meeting with members only
4h	Is the committee confident that internal audit is free of any scope restrictions and, if not, has it considered the impact of these on the annual Head of Internal Audit opinion?	Y		No other work is currently carried out by internal auditors
4i	Is the committee confident that internal audit	Y		Limited to audit work for the

	is free from any operational responsibilities or conflicts of interest that could impair its objectivity?			trust only
4j	Does the committee hold periodic private discussions with the Head of Internal Audit?	Y		At least annually.
4k	Has the committee evaluated whether internal audit complies with the Public Sector Internal Audit Standards?	Y		Internal audit present a periodically report to demonstrate compliance
4l	Has the committee agreed a range of internal audit performance measures to be reported on a routine basis?	Y		Internal audit report compliance with standards as part of progress report
4 m	Does the committee receive and review the Head of Internal Audit's annual opinion?	Y		Draft and final at the extraordinary meeting to approve the annual accounts
5	**External audit**			
5a	Do the external auditors present their audit plans and strategy to the committee for agreement and approval?	Y		
5b	Does the committee receive and monitor actions taken relating to prior years' reviews?	Y		Reported by EA at the meeting via follow up reports
5c	Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	Y		Audit findings report before opinion of the accounts
5d	Does the committee review the external auditor's value for money conclusion?	Y		At the meeting to approve the annual accounts
5e	Does the committee review the external auditor's opinion on the quality account when necessary?		N	External audit have not as yet been required to give an opinion on the Quality Account
5f	Does the committee hold periodic private discussions with the external auditors?	Y		Annually.
5g	Does the committee assess the performance of external audit?	Y		Within current constraints. This will bey strengthened by the role of the Auditor Panel
5h	Does the committee require assurance from external audit about its policies for ensuring independence?	Y		Comment included in audit plan
5i	Had the committee approved a policy to govern the nature and value of non-audit work carried out by the external auditors?		N	No. but no non audit work currently carried out
5j	Does the committee receive information on all non-audit work undertaken by external audit?		N	As above
5k	Does the committee review the proportion of audit and non-audit work every time the external auditors change?	Y		Via Audit Plan if there were any to consider
6	**Clinical audit**			
6a	Is the committee clear about where clinical audit assurances are received and monitored?	Y		The Quality and Safety Committee is the monitoring committee for clinical audit. The Audit Committee receives as part of its work plan periodic reports

6b	If the committee is NOT the main committee receiving direct feedback from clinical audit, does it receive a report from the relevant committee on the progress made by clinical audit during the year along with a clear view on the outcome of the annual work plan?	Y		6 monthly reports
6c	If the committee receives reports from clinical audit has it: • Reviewed an annual plan which is clearly linked to clinical risks and clinical assurance needs? • Received regular progress reports? • Monitored the implementation of management actions resulting from clinical audit reviews? • Received a report over the quality assurance processes covered by clinical audit activity?	Y		As above
7	**Counter (or anti-) fraud and security**			
7a	Is the committee aware of NHS Protect requirements in relation to counter fraud and security activity?	Y		
7b	Does the committee review the planned counter fraud and security work at the beginning of the financial year and in particular its scope and coverage?	Y		
7c	Does the committee satisfy itself that the work plan is derived from clear processes based on risk assessments and that coverage is adequate?	Y		Via LCFS and LSMS report
7d	Does the committee receive notification of any material changes to the plan?	Y		Via progress reports
7e	Does the committee receive periodic reports about counter fraud and security activity?	Y		
7f	Does the committee effectively monitor the implementation of management actions arising from counter fraud and security reports?	Y		
7g	Do those working on counter fraud and security activity have a right of direct access to the committee and its Chair?	Y		
7h	Do those working on counter fraud and security activity have the necessary technical knowledge and experience to ensure that work is carried out as it should be?	Y		Attended NHS Protect courses
7i	Does the committee receive and review an annual report on counter fraud and security activity?	Y		
7j	Does the committee receive and discuss reports arising from inspections by NHS Protect in relation to the quality of the counter fraud (and security) provision?	Y		These are rare, but are included within progress reports

8	**Annual report and accounts and disclosure statements**			
8a	Is the committee's role in the approval of the annual report and accounts clearly defined?	Y		At the extraordinary meeting
8b	Is the committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	Y		As above
8c	Does the committee specifically review: • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? • Changes in estimation techniques? • Significant judgements made in preparing the accounts? • Significant adjustments resulting from the audit? • Explanations for any significant variances?	Y		Reported by DoF and external audit
8d	Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	Y		
8e	Does the committee receive and review a draft of the organisation's annual governance statement?	Y		
8f	Does the committee receive and review a draft of the organisation's annual report and accounts?	Y		
8g	Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements (for example, as set by the Care Quality Commission, Monitor and the NHS Trust Development Authority)?	Y		An example is the process for assessing compliance with CQC standards. The committee received an update at each meeting of regulatory report received at the Quality and Safety Committee.
9	**Other issues**			
9a	Does the committee provide a summary report of its meetings to the next available governing body meeting?	Y		