NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	17 July 2018
Paper number	E1

Board Assurance Framework

For approval:	x	For assurance:		To note:	

Accountable Director	Michelle McKay CEO		
Presented by	Michelle McKay CEO	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners	x	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	x	Develop and sustain our business	x		

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	x	Operational Performance	x	Quality of Care	x
Finance and use of resources	x	Strategic Change	x	Stakeholders	x

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
QGC	June 2018	Approved changes as detailed
People and Culture Committee	July 2018	Approved changes as detailed with amendments to the 4ward metrics
Finance and Performance Committee	June 2018	Approved changes as detailed
Strategy and Planning Group	July 2018	Approved changes as detailed

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	All

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is recommended to approve the changes as detailed in the report.

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Executive Summary

The Board Assurance Committee has been reviewed by each of the responsible committees and the changes recommended are as follows:

Quality Governance Committee (risks R1.1, R1.2, R1.3, R2.1)

BAF risk	Action	Decision
Risk 1.1	• KPI - Change to the metric in respect of national audit reports (links to the Clinical Effectiveness Plan agreed by the QGC earlier this year) • Rationale - Removal of the sentence in respect of complaints process needing review • Control – addition of divisional governance leads • Gaps in control – addition of divisional governance leads and their role • Gaps in assurance – role of governance leads.	Agreed
Risk 1.2	• Reduction in risk score to 12 from 16 (reduction in severity from 4 to 3). The rationale for this proposal is the following: o Six improvement collaborate projects in place o Risk management strategy and handbook revised o Divisional quality improvement plans in place • Gaps in assurance include o clear plans for earned autonomy o CGG terms of reference – revision o Clear framework for trained staff in QI methodology	Agreed
Risk 1.3	• Insertion of the policy on Diagnostic Tests - Including the Requesting Process and Review with Acknowledgement	Agreed
Risk 2.1	Additional mitigating actions in place	Agreed

People and Culture Committee (risks R3.1, R3.2, R4.2, R4.3)

BAF risk	Action	Decision
Risk 3.1	• Rationale – add NED vacancy out to recruitment • Controls – add in 'and retention' plan • Add one NED vacancy to gap in control • Delete risk 3485	Agreed
Risk 3.2	Change target risk score to 1x5=5 Remove risk 3485	Agreed
Risk 4.2	Add gap in control – poor reputation with HEE in respect of junior doctors Add gap in assurance – stronger monitoring at P&C of HEE concerns Add gap in assurance – workforce transformation Remove risk 3485	Agreed

Finance and Performance Committee (risk R4.1)

BAF risk	Action	Decision
Risk 4.1	• Current risk score – remain at 20 but change the original 5x4 to 4x5 (likelihoodxseverity) • Change 'medium term financial plan' to 'sustainability plan' throughout the risk • Control - change finance training *to be refreshed* to *on-going* • Control – change January to June and £5m to £15m • Assurance – remove *weekly review of RTT* • Gap in control – remove *further use of resources* • Gap in assurance – remove sentence relating to Model	Agreed

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	Hospital.	

Strategy and Planning Group (risk R5)

BAF risk	Action	Decision

Risk 5	• KPIs
	  • Enabling strategies – addition of the strategies which have been approved by the Trust Board
	  • Financial control total – achieved
	• Controls
	  • Change three to four work streams led by the trust
	  • Change monitoring of the sustainability plan to TLG
	• Assurances
	  • Add in strategies that have been approved
	  • Add in sustainability plan
	  • Add in awaiting feedback from NHS I on the operating plan
	• Gaps in control
	  • Remove enabling strategies
	• Gaps in assurance
	  • Remove enabling strategies
	  • Remove operating plan
	  • Add in publish clinical services strategy in Q2
		Agreed

The Audit and Assurance Committee are being presented with the full BAF showing all track changes at their meeting on 18 July for assurance on the process.

Next steps
The Board Assurance Framework has been in place since July 2017. The BAF will be reviewed following Board approval of the strategic objectives, currently underway.

Background

The Board agreed at its meeting in January 2018 that the BAF would be considered bimonthly by the board committees and the Trust Board.

Issues and options

N/A

Recommendations

The Board is recommended to approve the changes as detailed in the report.

Appendices

The Board Assurance Framework, version 30

NHS
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Board Assurance Framework
June 2018
Version 30

Risk Heat Map				Current Score (likelihood x impact, arrow indicates any movement since last report) No Movement since last report ↔							
Strategic Objective	**Priorities**	**Risks**	**Outset Scores**	**<=9**	**10**	**12**	**15**	**16**	**20**	**25**	**Target Score**
1. **Deliver safe, high quality compassionate patient care**	P1.1 Embed and assure the revised ward to board governance structures and processes and improve the identification and management of risk	R1.1 If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	4x5=20			**3x4** →					**2x4=8**
	P1.2 Develop a more robust improvement, quality and safety culture across the Trust, including learning when things go wrong	R1.2 If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.	5 x 4 = 20			**3x4** ↓					**2x4 = 8**
	P1.3 Ensure the appropriate measures are taken to address all the quality and safety concerns identified by the CQC	R1.3 There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	4x4=16						5 x 4 = 20 ↔		**3 x 3 = 9**
2. Design healthcare around the needs of our patients, with our partners	P2.1 Improve urgent care and patient flow pathways across the whole system to ensure the care is delivered by the right person in the right place first time P2.2 Ensure the Trust meets its agreed trajectories for patient access and operational performance improvement in urgent and elective care	R2 Unless we work with our health and social care partners to understand flow across the system, then we may have inadequate arrangements in place to manage demand (activity)- which may impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc)	4x5=20						**4 x 5 = 20** ↔		**3x3=9**
3. Invest and realise the full potential of our staff to provide compassionate and personalised care	P3.1 Develop leadership capacity and capability at all levels within the organisation	R3.1 If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace- with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions	4 x 4 = 16			**3 x 4 = 12** ↔					**2x2=4**
	P3.2 Develop at all levels an organizational culture and set of behaviours that embody the Trust's values	R3.2 If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.	**3 x 5 = 15**				**3 x 5 = 15** ↔				**1x5=5**
4. Ensure the Trust is financially viable and makes the best use of resources for our patients.	P4.1 Systematically improve efficiency and sustain financial performance ensuring that the Trust delivers its financial control total.	R4.1 If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.	3x4=12						**4x5** ↔		**2x3=6**
	P4.2 A compelling vision for the Trust and a workforce strategy that supports the retention of current staff recruitment to vacancies and development of new	R4.2 If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently- with the potential for reduced	**5 x 4 = 20**			**3x4**					**3 x 3 = 9**

	roles	quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on staff resilience; poor retention of staff & inability to attract staff.				↓					
5. Develop and sustain our business	Develop a 5 year clinical service strategy that supports the clinical and financial sustainability goals described in the Herefordshire and Worcestershire STP. Strengthen our collaboration and partnership working with other providers in Worcestershire and beyond to ensure local access to a full range of high quality services.	R5 If we are unable to secure the support of our clinical workforce, community and STP stakeholders for the 5 year clinical strategy, we may not be able to make the changes required to ensure long term viability of services.	4x4=16					**4 x 4 = 16** ↔			**3x3=9**

Mapped to Single Oversight Framework

1. Leadership and Improvement Capability	2. Operational Performance	3. Quality of Care	4. Finance and use of resources	5. Strategic Change	6. Stakeholders
Invest and realise the full potential of our staff to provide compassionate and personalised care	**Design healthcare around the needs of our patients, with our partners**	**Deliver safe, high quality compassionate patient care**	**Ensure the Trust is financially viable and makes the best use of resources for our patients.**	**Develop and sustain our business**	**Design healthcare around the needs of our patients, with our partners**

Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients						Risk ID	R1.1
Risk Details	If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.							
Executive lead	Chief Medical Officer	Last Reviewed	June 2018	Target Date	July 2018	Review Group	QGC	
CQC Domain(s)	Safe	Caring	Responsive	Effective	Well Led			
Corporate Objective(s)	1	2.	3	4	5			

Risk Rating: Likelihood x Severity

	June 2018	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	20							
Current Risk Score	12	12	16	16	16	16	20	20
Target Risk Score	8		8	8	8	8	8	8
Risk Appetite	Low							
Direction of travel								

Relevant Key Performance Indicators

Metric	Trust compliance April 2018	Target
Complaints responded to within 25 days	77.87%	80%
5% Reduction in Number of serious incidents each year over next 5 years	Baseline – 122 (2017/18) YTD - 8	116 (31.3.19)
P M Review completion	45.11% (Mar 2018)	>60%
HMSR (rolling 12 mths) SHMI (rolling 12 mths)	104.55 (Feb-17 to Jan-18) – as expected 103.62 (Jan-17 to Dec-17) – as expected	Improving Band 3 better than expected
Compliance with NEWs Audit Compliance with Observations Accuracy (adult inpatient) NEWs Escalation (snap) % 2222- calls appropriately escalated % Unplanned admissions ICU with appropriate Escalation (adults only)	May 2018 98% 99% 99% 86% 100% 100%	100% 95% 95% 95% 85% 90%
Consider all published national audit reports and have produced a management summary and action plan, where relevant, for all national audit published reports.	97% (Feb 2018)	95% within 12 weeks (Mar 2019)
Friends and Family Test A&E Score Acute Score Outpatients Score	78.0% 96.3% 92.4%	>=95%

Rationale for current score	
The Trust Clinical Governance systems are not fully embedded from Ward to Board. There is a lack of understanding of risk within the organization.. The Trust has been rated as Inadequate by the CQC and is currently in Special Measures.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Quality Improvement Plan reviewed at Quality Improvement Board Quality Governance Committee receives monthly reports from Divisions National SI reporting system Trust BAF identifying risks to Trust objectives Corporate Risk Register Risk Management Strategy Risk awareness session held with the Board 6/06/17 & BAF discussion held 08/08/17 Patient Carer and Community plan approved Risk maturity review undertaken NHS I improvement director finalising corporate governance systems Review of AMD structure undertaken Divisions have named governance leads	Review of KPIs at the following Divisional performance and Accountability meetings Quality Improvement Board Clinical Governance Group Quality Governance Committee Quality Improvement Review Group NHSI performance Review meetings Complaints targeted approach with Divisions SI performance monitoring Agreed proforma with KPIs to report through to CGG OU risk maturity review Governance support in place Sept 2017-Mar 2018
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Gaps in personnel supporting divisional governance leads Robust working of governance leads	Review Divisional Governance meetings to ensure capability exists within the Divisions and provide training as required. Work with governance leads and strengthen governance teams

Related High Risks (15 and above and DATIX ID)

2591	**Medicine Risk Register:** EDS not completed in a timely manner	20	2873	**Corporate Risk Register:** If staff do not receive appropriate safeguarding training there is a risk that patients at risk of harm may not be identified	12
3325	**Corporate Risk Register:** There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16	3650	**Corporate Risk Register:** There is a risk that the Trust is unable to deliver safe and effective care due to medical staff vacancies	12
3522	**Risk register:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	16			

Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients					**Risk ID**	R1.2
Risk Details	If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.						
Executive lead	**Chief Nurse**	**Last Reviewed**	**June 2018**	**Target Date**	**July 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	Caring		Responsive		**Effective**	**Well Led**
Corporate Objective(s)	**1**	2		3		**4**	**5**

	Risk Rating: Likelihood x Severity							
	June 2018	April 2018	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17
Initial Risk Score	20							
Current Risk Score	12	16	20	20	20	20	20	20
Target Risk Score	8							
Risk Appetite	Moderate							
Direction of travel			Note 16 to 12, Severityxlikelyhood, 3x4, previously 4x4					

Relevant Key Performance Indicators		
Metric	**Trust compliance April 2018**	**Target**
F&F Test (Q4 17/18) Re care & treatment Re place to work	Likely/ extremely likely 60% 53%	70%
Discharges before 10:00	9%	15%
Number of staff training in quality service improvement and redesign (QSIR) methodology	0 4	TBA
CQC Well Led Domain	Inadequate	Requires improvement
Number of collaborative improvement projects	6 • IPC • Nutrition • Retention • PU • Falls • ACP fast track	6
QI Strategy in place Divisional Improvement plans in place	Approved	Yes
Improvement methodology training plan in place	Yes	Yes

Rationale for current score	
The Trust does not currently have an agreed QI framework as to how to utilize the trained staff in QI methodology. There is limited QI capacity within the organization. Variability in some areas eg hand hygiene compliance.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Quality Improvement Plan and Quality Improvement Board in place to monitor progress. Quality Improvement Strategy approved by Trust Board Patient carer and community plan approved by Trust Board SQuID system in place Quality Improvement methodology training plan in place and being progressed Harm review panels chaired by CNO/CMO well established Medicines management summit held in November 2017 Medicines Management Audit Plan NED & Exec programme of Safety walkabouts Exec quality audit programme Quality Impact Assessment process in place Senior Nurse statement of intent in relation to Quality monitoring Improvement plan in place for staff survey Risk improvement plan to improve risk maturity score from 2 to 3 in place Divisional quality improvement plans Trajectories and KPIs agreed Risk Management Strategy & handbook – June QGC/July Trust Board	KPI's for PMO projects KPIs for QIP projects Annual staff survey report. Monthly QIP exception reports Frailty Improvement 4ward programme Mandated professional standards Ward round/board round QIRG review of Improvement methodology NHS I review of IPC. Performance now green Oxford University Hospitals Trust Risk review report – progressed to Level 2 CQC report of visit in November 2018 shows improvement in 10 areas across Medical and Urgent & Emergency Care Divisional Quality improvement plans
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Bi-monthly monitoring of the Quality Improvement Strategy at CGG	Clear plans for earned autonomy CGG terms of reference to be revised Clear framework for using staff trained in QI methodology

Related High Risks (15 and above and DATIX ID)					
3482	**Corporate risk register**: There is a risk that patient safety, effectiveness and management may be compromised in ED	20	3341	**Risk Register:** Risk of patient harm and potential catastrophic risk of death for vulnerable and frail patient caused by C.difficile	15
2976	**SCSD Risk Register:** Failure to achieve JAG Accreditation	16			

Risk Description	**Principal Risk:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes								Risk ID	R1.3
Risk Details	There is a risk that patient safety and performance against objectives may be adversely affected. This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. The effect has potential for delays in communication, diagnosis, treatment and follow up within and without of the organisation. The impact is an increased patient safety risk, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.									
Executive lead	Chief Medical Officer	Last Reviewed	June 2018	Target Date	Dec 2018	Review Group	QGC			
CQC Domain(s)	**Safe**	Caring	Responsive	**Effective**	Well Led					
Corporate Objective(s)	1	2	3	4	5					

	Risk Rating: Likelihood x Severity								Relevant Key Performance Indicators		
									Metric	Trust compliance June 2018	Target
	June 2018	April 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Risk assessment of Clinical Information Systems Number of recommended actions completed	32	41
Initial Risk Score	16										
Current Risk Score	20	20	20	20	20	20	20	20			
Target Risk Score	9										
Risk Appetite	Low										
Direction of travel											

Rationale for current score

The Trust needs to be assured that adequate controls are in place to prevent serious incidents within Trust systems and processes. It is unknown when a similar incident could occur.
Internal audit report showed weaknesses in IT systems. Working group in place and actively undertaking the actions identified.
SI incident resulted in no harm.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Audit of electronic system for clinic letter generation and circulation with an associated action plan Harm review where communication with patients and or GPs has failed Staff training in place and on-going Reports via divisional governance reports to CCG on letters Task and finish group set up and meeting regularly Audit and Assurance Committee monitoring implementation of action plan	Review undertaken by Internal audit Backlog cleared from Bluespier Harm reviews completed Staff training underway and on-going
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Development of policy in respect of electronic viewing	Approval of Diagnostic Tests - Including the Requesting Process and Review with Acknowledgement

Related High Risks 15 and above and DATIX ID)

3522	**Corporate risk register**: There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	16

Risk Description	**Principal Risk :** The Trust is unable to design healthcare around the needs of our patients, with our partners					**Risk ID**	R2.1
Risk Details	Unless we work with our health and social care partners to understand flow across the system, then we will have inadequate arrangements in place to manage demand (activity) which will impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr emergency access standard; RTT; Cancer 62 days and diagnostics.)						
Executive lead	**Chief Operating officer**	**Last Reviewed**	**June 2018**	**Target Date**	**Sept 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	Caring		**Responsive**	**Effective**		Well Led
Corporate Objective(s)	1		**2**	3	4		5

Risk Rating: Likelihood x Severity									**Relevant Key Performance Indicators**		
									Metric	**Trust compliance April 2018**	**Target**
	June 2018	April 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17			
Initial Risk Score	20								Emergency Access Standard	75.32%	92%
Current Risk Score	20	20	20	20	20	20	20	20	Non-elective stranded patients	40.20%	15%
Target Risk Score	9								12hour breaches	44	0
Risk Appetite	High								Number of DTOC patients	36	21 (Jan 2018)
Direction of travel	⟷								Referral to Treatment	83.24% (Mar 2018)	89%
									Cancer 62 day	82.93% (Mar 2018)	85%
									Diagnostics	7.37%	<1%

Rationale for current score
The Trust is not currently meeting the four main national performance standards and has significant problems with flow of urgent care patients.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

Patient Flow programme in place RTT Recovery Plan Cancer Plan Diagnostic Plan System Level Plan and Escalation Framework	Integrated Performance Report Weekly Urgent Care & Flow Dashboard Weekly Cancer Dashboard to Cancer & RTT PTL meetings Elective access Board Weekly RTT PLT meetings A&E Delivery Board Urgent care escalation Meeting with NHSI Weekly Cancer Assurance call (NHSI & CCG) Monthly Cancer Board
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Failure to adhere to internal professional standards, escalate and follow escalation policy Limited impact of whole system working Lack of out of hospital pathway capacity Insufficient workforce to deliver Plans	Ensure all internal processes are followed in line with internal policies. Continue to work with system partners to develop strategies to ensure patients receive care in the right place at the right time. Implement Performance Framework System reset event planned early July 2018 Aconbury East development WMAS/CCG boundary changes under discussion

Related High Risks (15 and above and DATIX ID)

2148	**Corporate Risk Register:** Patients may be harmed following a delay in diagnosis due to lack of appointment capacity within Endoscopy	20	2709	**Corporate Risk Register**: Risk of delayed admission to critical care from full unit	16
3482	There is a risk that patient safety, effectiveness and management may be compromised in ED due to EXIT block.	20	3483	Patients may be harmed due to delays in treatment/waiting times	16
2981	**Medicine Risk Register:** Capacity	20	3637	There is a risk that inpatients cared for in Endoscopy recovery do not have adequate provisions & staffing to provide safe care	16
3482	**Corporate Risk Register:** There is a risk that patient safety, effectiveness and management may be compromised in ED.	20	2709	Risk of delayed admission to critical care as unit full	16
2689	Breaching national Emergency Access Standards	20	2858	15 minutes triage in ED – WRH	16
3361	**Medicine Risk Register:** SIAN area -ED WRH	20	2871	If RTT and non RTT reports are not consistently using new methodology, patients are not being managed through central WLs	16
2875	Co-horting patients under WMAS care	20	3483	Patients may be harmed due to delays in treatment/waiting times	16
3325	There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16	3659	There is a risk of delay in diagnosis and treatment for elective endoscopy patients cancelled due to inpatient outliers	16
2299	**Corporate Risk Register:** Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision	16	2634	Patients with Mental health illness in ED may have reduced quality of care and delay in assessment	**15**
3484	There is a risk of sub optimal patient care in surge areas	16	3363	Failure to deliver timely care to patients admitted for elective procedures and on an elective pathway	15

Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care				**Risk ID**	R3.1
Risk Details	If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions					
Executive lead	**Director People and Culture**	**Last Reviewed**	**June 2018**	**Target Date**	**April 2019**	**Review Group**	**P&C**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**		**Well Led**
Corporate Objective(s)	1	2	**3**	4		5

	Risk Rating: Likelihood x Severity							
	June 2018	April 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17
Initial Risk Score	16							
Current Risk Score	12	12	12	12	12	12	16	16
Target Risk Score	4							
Risk Appetite	High							
Direction of travel								

Relevant Key Performance Indicators		
Metric	**Trust compliance April 2018**	**Target**
CQC well led domain rating	requires improvement	Good (Jun 2019)
Fit and Proper Persons Test is completed for all of the leadership team	100%	100%
4Ward (Net leadership score and wisdom in the Board)	Net Leadership Score	Net Leadership score 60% CP3 Net Leadership score of 50% for CP2 Net Leadership score of 45% for CP1
Staff survey	March 2018 – bottom quartile	Middle quartile (March 2019)

Rationale for current score	
The Trust Board is complete with one interim position (currently being advertised). NED vacancy out to advert	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Executive Team appointed NEDs appointed. Board development Programme Culture Change programme (4Ward) including one-on-one coaching for TLG and Board Recruitment & retention plan in place Workforce transformation programme underway People and Culture strategy approved by Trust board	Staff survey results Staff FFT CQC rating on Well Led domain Appraisal KPIs Net Leadership score Net culture score People and Culture sub-committee monitoring actions P&C Strategy in place 4ward culture programme fully supported
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of Trust wide Training needs analysis One NED vacancy	

Related High Risks (>14 and DATIX ID)

Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.2
Risk Details	If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.						
Executive lead	**Director of People and Culture**	**Last Reviewed**	**June 2018**	**Target Date**	**Sept 2018**	**Review Group**	**P&C**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	**3**	4			5

	Risk Rating: Likelihood x Severity								**Relevant Key Performance Indicators**		
									Metric	**Trust compliance April 2018**	**Target**
	June 2018	April 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17			
Target Risk Score	5 (1x5)								4Ward Net culture score	Net culture score for CP2 55%	Net culture score for CP3 – 60% Net culture score for CP2- 50% Net culture score for CP1- 45%
Initial score	15										
Current score	15	15	15	15	15	15	15	15			
Risk Appetite	Significant								Wisdom in the Board score		
Direction of travel	⟺								NHS Staff Survey 2017 Staff Engagement Metrics Staff FFT – recommend as place to work	3.7 50%	national average 62%

Rationale for current score
There are significant cultural and behavioural issues within the Trust that require action. The Trust has engaged external support to deliver a cultural change programme over the next three years.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
cultural change programme launched Oct 2017 Culture steering group in place. Board development Programme in place Wisdom in the workplace programme to support cultural change throughout the Trust 4ward programme in place P&C strategy approved	Staff survey results Staff FFT CQC rating on Well Led domain Appraisal KPI's Net Leadership scores Concerns raised via FTSU Guardian
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
4Ward programme not fully rolled out Communications campaign re zero tolerance on bullying and harassment	Deliver cultural change programme.

Related High Risks (15 and above and DATIX ID)		
2791	**Corporate Risk:** Inappropriate staffing levels	20

Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.1
Risk Details	If we do not have in place effective organizational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.						
Executive lead	**Chief Finance Officer**	**Last Reviewed**	**June 2018**	**Target Date**	**March 2019 +1/4ly gateway checks**	**Review Group**	**FPC**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	3	**4**			**5**

	Risk Rating: Likelihood x Severity (4x5)								**Relevant Key Performance Indicators**		
									Metric	**Trust compliance June 2018**	**Target**
	June 2018	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017	Compliance with monthly control total	Not achieved	Per the financial plan
Initial Risk Score	12								CIP delivery in Line with Plan	YTD M2 £8k adverse to plan	Per the financial plan
Current Risk Score	20	20	20	20	20	20	20	20	Operational Metrics linked to STF	Not compliant at the end of May 18	Per the agreed trajectories
Target Risk Score	6								Compliance with Capital Resource Limit (Forecast)	Compliant	Per the financial plan
Risk Appetite	Moderate								Carter productivity data through model hospital	Model Hospital key opportunity areas identified and being developed into action plans aligned to sustainability plan	Per operational plan
Direction of travel									Better Payment practice Code	Stabilised in Q4. Not compliant	95%

Rationale for current score	
There are risks to the control total in 2018/19 due to the scale of improvement required within the Trust. The Trust is in line with the 2018/19 medium term financial plan.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

Finance and Performance Committee ensuring that risks are being acted on..
 	
Detailed Sustainability Plan is in place:
• Divisional plans focused on:
  ○ Cost control actions – Medical Staff, Job Planning, Additional Sessions & Agency Control, Nurse roster management, Agency Cap, automated procurement system
  ○ Detailed budget analysis at directorate level (monthly)
  ○ Activity Data Quality, recording and coding
• Corporate led grip and control initiatives including implementation of financial recovery authorization limits as outlines in SFIs / SoD
• Finance training on-going with all budget managers to ensure compliance with Trust procedures
• Identification of non-recurrent benefits to mitigate financial risks in 2018/19
 	
Strengthened Governance
• Fortnightly confirm and challenge sessions established with CFO (Clinical Divisions and Corporate Departments). Escalated to weekly where performance is not on track
• Increased frequency of meetings with NHSI regional team to oversee progress (Delivery Board / PRM)
• Meetings with NHSI national team
 	
CIP programme integrated with Model Hospital and focus on key projects with highest potential return
• Active engagement with national NHSI Model Hospital team to maximize results
• Acceleration of key projects (theatre productivity, E-Rostering etc) with support of 4Ward culture programme
• Turnaround Director in post and driving development of Sustainability Plan
 	
Close monitoring of performance against capital programme and strengthened capital expenditure controls. Any approved schemes not yet committed are being reviewed through Capital Prioritisation Group and reported to FPC. Schemes linked to loan funding are held until a decision on the Trust's Loan Application is received. The loan application has been resubmitted during June 2018 to request emergency release of £15m to progress critical schemes.
 	
Daily Cashflow forecasting and rephasing of cash draw down requirements in line with the operating plan.
	Monitoring of development and performance against CIP targets
	Monthly finance reports with detailed analysis of performance v control total and actions identified in Financial Recovery plans
	Numbers of breaches of agency cap
	External review through NHSI, internal audit and benchmarking
	Better Payment Practice Code performance
	Minimum cash balances against plan
	Monitoring of debt levels
	Capital spend variance to CRL

Gaps in controls and assurances: what additional controls and assurances should we seek?	Mitigating Actions: what more should we do?
QIA process for CIPs not embedded	Ensure QIA meetings are timely and effective. Ensure all CIP projects have completed and signed off PIDs & QIAs.

Related High Risks (15 and above and DATIX ID)					
3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16	3291	**Corporate Risk:** there is a risk that the financial deficit is worse than planned	16

Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.								**Risk ID**	R4.2	
Risk Details	If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on substantive staff resilience; appropriate deployment of staff and poor retention of staff & inability to attract staff.										
Executive lead	**People & Culture Director**	**Last Reviewed**	**June 2018**	**Target Date**	**April 2018**	**Review Group**	**P&C**				
CQC Domain(s)	Safe	**Caring**	**Responsive**	**Effective**	**Well Led**						
Corporate Objective(s)	1	2	3	**4**	5						

Risk Rating: Likelihood x Severity									**Relevant Key Performance Indicators**		
									Metric	**Trust compliance March 2018**	**Target**
	June 2018	April 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17			
Initial Risk Score	20								Vacancies	% 7.38%	7% or less
Current Risk Score	12	12	16	16	16	16	20	20	Turnover rate	11.04%	10<>11%
Target Risk Score	9								Sickness absence rates	3.93%	<3.9%
Risk Appetite	Moderate								Compliance with Safer staffing	96.2% (day) 103% (night)	95%
Direction of travel	⟺								% bank and agency spend (P&C scorecard)	Agency as % of gross cost 7.01% ⇑ Bank as % of gross cost 7.37% ⇓ (Feb 2018)	5% 7%

Rationale for current score
The Trust reputation is poor so will struggle to attract and retain staff. 40% reduction in medical vacancies in the last 9 months. Nurse turnover and vacancies in line with national average. Current vacancy rate for trained nurses reduced in last quarter.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Recruitment & retention plan approved and in place. Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts being recruited to. People and Culture strategy approved and being implemented Task and Finish group in place for medical and nursing staff to enhance recruitment and retention Overseas recruitment to India Raised trust profile with recruitment video	HR workforce reports & Score Card Agency use/ shift fill rate. Performance against recruitment trajectory Recruitment KPIs Turnover rate
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Hard to recruit roles – not available in national market place Insufficient numbers of junior doctor placements Lack of development of new roles eg nurse practitioners Poor reputation with HEE in respect of junior doctors	Strategic workforce plan in development Stronger monitoring at P&C committee of HEE concerns Workforce transformation

Related High Risks (15 and above and DATIX ID)

2791	**Corporate Risk Register:** Inappropriate staffing levels	20	3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20			
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16	3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16			

Risk Description	**Principal Risk:** The Trust is unable to develop and deliver a long term sustainable clinical services strategy					**Risk ID**	R5	
Risk Details	If we are unable to secure the support of our community and STP stakeholders for the clinical services strategy, we may not be able to make the changes required to ensure long term viability of services							
Executive lead	**Director of Strategy & Planning**	**Last Reviewed**	**June 2018**	**Target Date**	**3 years**	**Review Group**	**Strategy & Planning Group**	
CQC Domain(s)	Safe	**Caring**	**Responsive**	**Effective**			**Well Led**	
Corporate Objective(s)	1	2	3	4			**5**	

Risk Rating: Likelihood x Severity								
	June 2018	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	16							
Current Risk Score	16	16	16	16	16	16	16	16
Target Risk Score	9							
Risk Appetite	High							
Direction of travel	⟺							

Relevant Key Performance Indicators		
Metric	**Trust compliance June 2018**	**Target**
Board approved clinical strategy	In development	Approved strategy
Enabling strategies in place e.g. estates. workforce	Quality Improvement and associated plan in place; P&C strategy in place; Estates in development	Approved strategies
Related medium term financial sustainability plan	In development	Approved plan
Achievement of Trust agreed financial control totals going forward	Achieved revised financial control total	Trust meets agreed totals

Rationale for current score

The Trust has completed the FoAHSW programme but the impact on the clinical and financial viability of services has been confined to a small number of Trust specialties. As a three site Trust with a significant underlying financial deficit and ongoing recruitment challenges there is the need for a more far reaching, more radical strategy for Trust sites and services. Currently the STP plans are also underdeveloped There is an issue that as NHSE resources are aligned with STPs the pace of change will increase and the Trust needs to have a clear clinical services strategy for inclusion in the STP that it can use STP mechanisms and processes to support and drive. There is a risk from competing priorities for clinical leadership capacity to develop the strategy.					
Controls: what are we currently doing about the risk?			**Assurances: how do we know if the things we are doing are having an impact?**		
The Trust is engaged in the STP at Partnership Board level and at Delivery Board level and is leading four of the key STP work streams. The Trust has convened a Clinical Council reporting to the Strategy & Planning Group for the purpose of 1. Overseeing full implementation of the FoAHSW model 2. Sponsoring and overseeing the development of the Trust clinical service strategy and 3. Overseeing the sustainability of clinical services at the Trust The Council will review the recommendations from the Herefordshire and Worcestershire STP Clinical Reference Group and ensure alignment with the Trust's strategic clinical service priorities. TLG monitoring financial recovery (sustainability plan)Two year operating plan 2017-2019 completed Risk based capital prioritisation plan Turnaround director in place			Improvement in the clinical and financial sustainability of Trust services and the financial sustainability of the Trust overall. Operating plan 2017-19 reviewed by NHSI and awaiting feedback First high level draft in place. Enabling strategies – Quality Improvement and associated plans; P&C in place. Estates in development Plans on a page for the recovery plan in place Sustainability plan in place		
Gaps in controls and assurances: what additional controls and assurances should we seek?			**Mitigating Actions: what more should we do?**		
No current overarching clinical strategy however development work has started			Clinical engagement sessions to take place in the summer Second version of Strategy – June 2018 Strategy published during Q2		
Related High Risks (15 and above and DATIX ID)					
3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16	3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16