BSUH Board Assurance Framework 2015 /2016 – Quarter 3 March 2016

Ref: 1	**Fundamental**	**Aligning capacity and demand**	**Assurance Committee**	**Board of Directors**
BAF 15/16	**Risk Description**	**Failure to deliver the required changes in capacity to support achievement of key access targets, quality of care, patient and staff experience**		

Cause (What might cause the risk to occur?)	• Increase in bed occupancy • Reduction in acute bedded capacity • Limited space for additional beds at the RSCH site • Updated bed modelling indicates that BSUH has a shortfall of 56 beds at 90% occupancy in 2015/16 • Differential models of community provision, and access criteria • Fragmentation of pathways across the system with multiple hand-offs,
Consequences (What are the possible consequences if the risk occurs?)	• Insufficient capacity to maIntain patient flow • Continued shortage of physical bed capacity on the RSCH site • Higher numbers of patients Medically Ready for Discharge (MRD) • Increased number of sub-acute patients occupying acute beds • Negative impact on patient safety and experience and non-compliance with regulatory standards • Non-delivery of the A/E 4 Hour standard • Consequent impact on achivement of 18 week (RTT) performance • Increased demand in Primary Care • Impact on system wide credibility and reputational standard for the organisation
Risk Owner	**Director of Change**

Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity (Impact X likelihood)	16	**High**

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Capacity Mobilisation Group oversees delivery of agreed programmes including; ➢ Overall monitoring of agreed planned changes in required capacity ➢ Opening of Newhaven Downs Sub-acute beds (20 beds) ➢ Opening of additional capacity on Plumpton Ward (PRH) for medically ready for discharge patients ➢ Delivery of Internal LOS efficiencies associated with site reconfiguration plans and wider directorate planned productivity improvements ➢ Development of Hospital at Home Initiative

	• SRG monitors system wide improvements including commissioner and community based changes • Internal Urgent Care recovery Programme covering a range of initiatives including AMU and Right Care Right Place Each Time • ECIST Implementation plan						
Current Risk	Current Impact	4	Current Likelihood	4	Current Severity	16↔	**High**

Action for Further Control (Summary)	**Monitoring Method (Assurance)**	**Frequency**	**Action Owner**	**Effectiveness**	**Due Date / Complete**
Completion of Level 5 Plan to improve flow	Urgent Care Programme Board	Monthly	Chief Operating Officer	Adequate	Completed December 2015 monitoring implementation Daily and weekly
Phased roll out of *Right Care, Right Place, Each Time* programme	Urgent Care Programme Board	Monthly	Clinical Director	Adequate	Phased roll-out continues
Ensure extra capacity planned (Newhaven, Hospital at Home, Plumpton) comes on stream	Capacity Mobilisation Group	Fortnightly	Deputy Chief Executive	Adequate	Newhaven & Plumpton opened in Novembe

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control	Adequate				
Risk assigned to:	Director of Change	Signed	Brendan Ward	Date	March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	**4**	**Likelihood**	**2**	**Severity**	**8**	**Moderate**

Justification for risk appetite: The management of the risk is contingent on LHE partners developing and managing capacity outside the acute setting, and is subject to demographic changes which may be difficult to foresee**.**

Ref: 2	Objective All corporate objectives	Fundamental Site reconfiguration Modern Estate / 3T's	Assurance Committee	Board of Directors

BAF 15/16	Risk Description	200 year old clinical infrastructure at RSCH and 75 years old infrastructure at HWP which is no longer fit for purpose.

Cause (What might cause the risk to occur?)	> Non-delivery of 3Ts programme
Consequences (What are the possible consequences if the risk occurs?)	> Inability to meet strategic and developmental goals as the Regional Tertiary Centre > Inability to meet forthcoming clinical challenges > Poorer patient experience, especially in DGH services for the Brigton & Hove population > Significant impact on immediate operational capacity and delivery. > Loss of reputation
Risk Owner	Deputy Chief Executive (Director of 3Ts)

Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	5	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	> HM Treasury approved FBC in October 2015. > Renewed focus on delivery of programme on a particularly constrained site. > Regular update to 3Ts, Programme Board, Clinical Management Board and Trust Board. > Site Reconfiguration Programme will assist in managing medium term risk at Hurstwood Park.

Current Risk	Current Impact	5	Current Likelihood	3	Current Severity	15↔	High

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Continue briefing meetings with key stakeholders. Current main issue it the closure of part of the South Service road on 22nd April and ensuring 3T's have adequate	Regular reports to 3Ts Programme Board, CMB and Board. Weekly Look ahead meeting with	Monthly Weekly	Duane Passman, Director of 3Ts	Adequate	Monthly and weekly review with Key concerns escalated

controls in place to ensure that site will continue to work operationally safely	Key BSUH staff and LoR as Contractor Site reconfiguration meeting with 6 monthly look ahead.	Monthly			
Approval required for FBC from HM Treasury	Regular reports to 3Ts Programme Board, CMB and Board	Monthly	Duane Passman, Director of 3Ts	Adequate	Complete
Business Case has been approved by TDA and HMT. Approval letter received. Exact mix of PBC and loan to be confirmed. The challenge is now to progress the construction programme without compromising Trust operational capacity.	Programme governance arrangement s to be refreshed in the light of approval. Challenge remains of engaging operational staff in the deliver	Monthly	Duane Passman, Director of 3Ts	Adequate	Monthly review
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control			Adequate		
Risk assigned to:	Director of 3T's	Signed	Duane Passman	Date	March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	4	**Likelihood**	2	**Severity**	8	Significant

Justification for Risk Appetite: Outcome is to deliver programme. On-going risk is the ability to maintain financial sustainability before, during and after construction.

Ref: 3	**Objective**	**Excellent outcomes Great experience**	**Assurance Committee**	**Quality and Risk Committee**
BAF 15/ 16	**Risk Description**	**Non-compliance with regulatory standards and statutory duties leading to regulatory or enforcement action**		

Cause (What might cause the risk to occur?)	• Poor patient flow has a negative impact on patient experience, access and safety • Shortfalls in statutory and mandatory training • Failure to ensure safe staffing levels • Use of personal devices in clinical settings breaches information governance responsibilities • Failure to follow requirements and obtain assurance re: Safe Water Management. • Failure to follow requirements and obtain assurance re: Health and Safety and Fire Safety Arrangements • Failure to follow Duty of Candor requriements						
Consequences (What are the possible consequences if the risk occurs?)	• Use of enforcement powers by regulators • Harm to organisational reputation and staff morale • Financial penalties • Litigation • Loss of autonomy						
Risk Owner	Chief Nurse & Medical Director (Safety & Quality); Director of People (Equality); Director of Health Informatics (Information Governance);						
Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	5	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity (Impact X likelihood)	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• CQC Improvement plan and governance of action plan • Improving quality and patient experience visits to service areas • Urgent care recovery plan and governance • RTT recovery plan and governance with specific risks and actions identified. • Appraisal development plan • Development of Virtual Learning Environment (VLE) for statutory and mandatory training • Information governance policies and procedures overseen by Information Governance Committee

	• Responsible and accountable persons for Trust statutory duties • Statutory policy framework • Water Safety Committee governance • Health and Safety and Fire Safety governance. • Annual internal audit of Risk Management arrangements and audit of other compliance areas. • Corporate induction for all staff incorporates mandatory & statutory training in various formats						
Current Risk	Current Impact	5	Current Likelihood	4	Current Severity	20↔	**High**

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Completion of outstanding actions in the CQC improvement plan	Clinical Management Board Quality and Risk Committee Improving quality meeting with directorate attendance as part of corporate review	Bi-monthly Quarterly	Associate Director of Quality	Inadequate	Bi-monthly review
Implementation of VLE	People Board Finance, People and Performance Committee	Monthly Monthly	Assistant Director of HR	Inadequate	Monthly review until complete
Improvement in recording, reporting and uptake of appraisals. New format for appraisal in place with training provided.	People Board Finance, People and Performance Committee	Monthly Monthly	Operational Director of HR	Adequate	Ongoing with regular improvement
Agreement of framework and infrastructure to manage IG and security risks.	Executive Team	Monthly	Director of Health Informatics	Adequate	Bi-monthly review
Due regard – all policies, services and changes to functions are	Executive Team	Monthly	Deputy Chief Executive	Inadequate	On-going with regular improvement

subjected to evidence based due regard that is reflected throughout the policy/document. Water Safety arrangements suitable and sufficient with suitable Assurance arrangements.	Finance, People and Performance Committee	Monthly	Chief Financial Officer and Chief Nurse	Adequate	Monthly review
Health and Safety and Fire Safety concerns are escalated but not always resolved due to competing pressures which leads to statutory non-compliance e.g. storage of beds	Health and Safety Committee Finance, People and Performance Committee	Bi-monthly Monthly	Executive Team	Adequate	Bi Monthly review
Improved management and control of waste, updating information to staff, and policy and procedures. Tender process for the Waste Management contract	Health and Safety Committee Waste tender process	Bi-monthly Weekly	Chief Financial Officer and Chief Nurse Director of Facilities and Estates	Adequate	Bi Monthly review Final Draft to HIPACC & H&S Committee March for comment.
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	
Risk assigned to:	Chief Nurse & Medical Director (Safety & Quality); Director of People (Equality); Director of Health Informatics (Information Governance);		Signed		Date: March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	**4**	**Likelihood**	**2**	**Severity**	**8**	**Moderate**

Justification for risk appetite: The consequence of no compliance will vary but due to the complexity, scope, changeability and scale of meeting all statutory requirements even if there are robust assurance arrangements the likelihood of this occurring will be greater than rare.

Ref: 4	**Objective**	**Excellent outcomes Great experience**	**Assurance Committee**	**Quality and Risk Committee**
Ref: BAF 15/16	**Risk Description**	**Adverse outcomes and experience for patients arising from poor patient flow**		

Cause (What might cause the risk to occur?)	• Delays in assessment, treatment and admission • Cancellation of operations • Inappropriate use of recovery; surgical and medical outliers; poor flow from HDU/ITU to wards • Delayed transfers of care • Inability to secure additional capacity						
Consequences (What are the possible consequences if the risk occurs?)	• Poor patient experience • Avoidable harm • Non-compliance with CQC fundamental standards						
Risk Owner	Chief Operating Officer						
Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	5	Initial Severity (Impact X likelihood)	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Urgent care recovery plan • Patient flow and escalation policy • Safety and quality governance arrangements • AMU action plan • Priority bed pass for cancer patients						
Current Risk	Current Impact	4	Current Likelihood	5	Current Severity	20↔	High

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
RTT recovery plan with specific risks and actions identified for each Directorate.	Clinical Management Board Board of Directors Meeting with Directorates re RTT recovery plan progress	Monthly Weekly	Chief Operating Officer & Deputy COO Planned Care	Inadequate	Monthly report to Board
Capacity mobilisation plan	Clinical Management Board	Monthly	Deputy Chief Executive	Inadequate	Monthly report to Board
Implementation of level 5 plan	Clinical Management Board Board of Directors	Monthly	Chief Operating Officer & Clinical Director (Acute Floor)	Adequate	Monthly report to Finance, People and Performance Committee and Board
Phased roll out of *Right Care, Right Place, Each Time* programme	Urgent Care Programme Board	Monthly	Deputy Chief Executive	Adequate	Monthly review
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	
Risk assigned to:	Chief Operating Officer	Signed	Mark Smith	Date	March 2016

To be agreed by Trust Board

Risk Appetite	Impact	2	Likelihood	3	Severity	6	Moderate

Justification for risk appetite: There could be regular large fluctuations in demand often outside the Trust's control. But the impact can be reduced by good controls, built-in contingency and escalation.

Ref: 5	Objective	Excellent Outcomes Great Experience Empowered & skilled staff	Assurance Committee	Quality and Risk Committee
Ref: BAF 15/ 16	Risk Description	Failure to ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of patients across all services.		

Cause (What might cause the risk to occur?)	• National and local shortages of staff in hard to recruit areas, both nursing and medical • Delays in recruitment processes from job application to working on the wards • Delays in recruitment to increased nursing establishment • Staff turnover rates • Poor team working in some areas leading to staffing challenges • National ceiling on agency staff and use of extra capacity further stretch existing resource
Consequences (What are the possible consequences if the risk occurs?)	• Negative impact on patient safety and experience • Non-compliance with regulatory standards (specialtiy areas of nursing) or guidance on safe staffing levels.
Risk Owner	Medical Director & Chief Nurse

Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	5	Initial Severity	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Comprehensive review of nurse staffing levels and acuity and dependency of patients • Appointment of supernumerary band 7s • Implementation of E-rostering on all wards • Publication of planned and actual nurse staffing by shift • Monitoring of shift by shift staffing levels to ensure safe staffing • Monthly and six monthly Board reports on safe staffing by acuity and dependency of patients. • Escalation of any staffing level which breaches the set ratios through the four times daily operational meetings • Workforce element of site reconfiguration programme • Short-term mitigation plans to address deficits in medical staffing • New accelerated recruitment process in place including local, national and international recruitment.

Current Risk	Current	4	Current	5	Current	20↔	High

	Impact		Likelihood		Severity		

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Recruitment plans to address current vacancy factors which will include a marketing plan to highlight BSUH as a place to live and work. On-going local, national and international recruitment	Monthly and six monthly reports on safe staffing to Board of Directors	Monthly	Chief Nurse	Adequate	On-going and reported monthly But improvement in Nursing recruitment.
Strategies to recruitment in medical staffing, including action plans in challenged specialties	Periodic reports from Medical Director to Quality and Risk Committee and Board of Directors	As required	Medical Director	Adequate	Controlling rather than resolving. Monthly review
Growing the BSUH workforce in hard to recruit areas linked to the recruitment plan.	Monthly and six monthly reports on safe staffing to Board of Directors	Monthly	Chief Nurse	Inadequate	To be linked to action above and will part of role of new B9 Head of Nursing – Education
Increasing the number of practice educators to support newly qualified nursing staff. Impact of revalidation required in January 2016 for Nurses.	Monthly and six monthly reports on safe staffing to Board of Directors	Monthly	Chief Nurse	Inadequate	On-going and reported monthly
Further implementation of E rostering- rolled out to all nursing staff. Detailed action plan in progress to improve compliance	Progress report to Audit Committee in September 2015	Monthly	Chief Nurse	Inadequate	On-going and reported monthly End Nov 2015 for turnaround report
Medical leadership and engagement plan	Safety & Quality review HR review Performance review	Monthly	Medical Director	Inadequate	On-going and reported monthly
Comprehensive end to end review of the recruitment process.	Finance, People and Performance Committee and Audit Committee	Bi Monthly	Operational Director of HR	Adequate	Monthly review
Self-assessment against 7 day supply	Clinical Management Board	Bi-monthly	Medical Director	Adequate	Gaps have been

of services and actions developed in relation to medical review at PRH; therapies services and interventional radiology and angiography. Re-assessment will be undertaken and priorities identified for implementation in 2015/16 and 2016/17	Board of Directors				identified but actions need to be agreed to improve 7 day services. Review Bi-monthly until complete
Review cover for maternity leave and agree guidance	Clinical Management Board	Bi-monthly	Deputy Chief Nurse	Inadequate	On-going as not money to provide cover

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control	Inadequate						
Risk assigned to:	Chief Nurse and Medical Director	Signed	Sherree Fagge Steve Holmberg		Date	March 2016	

To be agreed by Trust Board

Risk Appetite	**Impact**	4	**Likelihood**	3	**Severity**	12	Significant

Justification for risk appetite: This is a national issue which is impacted by the local economy and therefore will difficult to resolve impact or reduce likelihood to below possible.

Ref: 6	**Objective**	**Excellent outcomes Great experience**	**Assurance Committee**	**Quality and Risk Committee**
Ref: BAF 15/ 16	**Risk Description**	**Inadequacy of whistle-blowing arrangements inhibits development of learning and improvement culture**		

Cause (What might cause the risk to occur?)	• Roles and responsibilities within the Trust whistle-blowing policy are unclear • Staff are unclear about, or unable to access routes for raising concerns • Trust response insufficient to concerns which have been raised						
Consequences (What are the possible consequences if the risk occurs?)	• Inability to learn from staff (and patient) concerns • Impact on patient safety and experience, and performance • Breach of regulatory standards and statutory duties • Disengagement from whistle-blowing processes						
Risk Owner	Director of People						
Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity (Impact X likelihood)	16	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Whistle-blowing (raising concerns) policy • Patient Safety Ombudsman • Patient Safety Ombudsman Panel • Local Counter Fraud Specialist (LCFS) & Compliance Manager • LCFS reports to the Audit Committee (quarterly)						
Current Risk	Current Impact	4	Current Likelihood	4	Current Severity	16↔	High

Action for Further Control (Summary)	**Monitoring Method (Assurance)**	**Frequency**	**Action Owner**	**Effectiveness**	**Due Date / Complete**
Review of whistle-blowing framework, supported by Public Concern at Work (PCAW)	Board of Directors	Six-monthly	Director of People	Inadequate	Consultation of new policy in April, implementation May

					2016.
Implementation of revised whistle-blowing framework and appointment to roles to support this framework	Finance, People and Performance Committee Quality and Risk Committee	Quarterly	Director of People	Inadequate	May 2016
Development of range of personnel and routes, internal and external, to support staff who raise concerns	Finance, People and Performance Committee Quality and Risk Committee	Quarterly	Director of People	Inadequate	May 2016
Development of process for recording all formal reports of incidents and concerns	Finance, People and Performance Committee Quality and Risk Committee I	Quarterly	Director of People	Inadequate	May 2016

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control					
Risk assigned to:	Director of People	Signed	Helen Weatherill	Date	March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	**2**	**Likelihood**	**2**	**Severity**	**4**	**Moderate**
Justification for risk appetite: This is risk is with the Trust's ability to mitigate with effective governance and assurance processes in place.							

Ref: 7	Objective	High Productivity	Assurance Committee	Finance, People and Performance Committee
Ref: BAF 15/16	**Risk Description**	**Inability to Deliver Financial Plan**		

Cause (What might cause the risk to occur?)	• Efficiency Savings cannot be achieved • Failure of planned service changes – inability to control costs • Failure of 2015/16 contractual arrangements to deliver local health economy objectives • Income from local contracts decreases • Activity level below expectations therefore does not deliver activity levels required • Inability to recover income from commissioners • Fragmented and uncertain commissioning landscape • Internal budgets are not managed and delivered without financial control on spending e.g. over spend on agency staffing
Consequences (What are the possible consequences if the risk occurs?)	• FT application delayed • 3Ts project could be impacted • Major service developments delayed or inability to proceed • Impact on Cash – inability to pay creditors/workforce
Risk Owner	Chief Financial Officer

Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	5	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• CIPS (Cost Improvement Programmes) delivery units monitoring non-delivery of CIPS. • Financial Performance Review with CFO. • Change Board to ensure delivery of major change programme including the Efficiency Programme. • Collaborative working with Commissioners on LHE delivery plans. • Contract negotiations have an objective of reducing Trust exposure to risk via LHE Heads of Agreement. • Joint working on redefined pathways with commissioners and other local providers. • Proactive work to ensure Trust service plans and strategies align with Trust ambitions. • Investment and Prioritisation group – scrutiny and approval process.

Current Risk	Current Impact	5	Current Likelihood	4	Current Severity	25↑	High

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Directorate Performance Reviews – Escalation process to review underperforming services and agree mitigation as part of performance meetings.	Clinical Management Board	Monthly	CFO	Inadequate	Review monthly
Proactive contract management and processes for review and intervention.	Monthly contract monitoring report to Management Board	Monthly	Gareth Hall	Adequate	Review Monthly
Collaborative working to assess finance drivers across all providers & commissioners in LHE via LHE PMO	SEG – Local Chief executive steering Group	Monthly	CFO / CEO	Inadequate	On-going – Drive and delivery is not robust.
Clinical Management Board meeting focused on delivery of operational and financial plans	Clinical Management Board	Fortnightly	Clinical Management Board	Adequate	Bi-monthly report
Checkpoint and Exec Dashboard produced on a weekly basis to provide Executive regular update on performance of the Efficiency Programme including significant risks and issues to delivery	Executive Team, Change Board	Fortnightly	Change Board	Adequate	Weekly
Trust Financial and Business Planning process agreed and now in place. Led by Chief Financial Officer supported by Deputy Chief Financial Officer.	Executive Team	Monthly and then business planning quarterly	CFO	Adequate	Review Monthly
Develop Business planning process for 2016/17.	Clinical Management Board Board of Directors	Fortnightly Monthly	Deputy Chief Executive	Adequate	March 2016

BSUH Board Assurance Framework 2015 /2016 – Quarter 3 March 2016

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Efficiency Programme for 2016/17 to be developed and be further refined to including key milestones and KPI's.	Change Board.	Fortnightly	Programme Delivery Unit Lead	Adequate	Fortnightly
Service line management enabling service development of business plan for current and future financial sustainability.	Finance, People and Performance Committee	Monthly review	Clinical Chief of Finance	Adequate	Quarterly review.
Strengthen the Change Board.	Finance, People and Performance Committee	Monthly review	Clinical Chief of Finance	Adequate	Monthly review
Impose additional controls around use of temporary staff and non-pay send. Now in place with weekly non pay review meeting for approval. Emails sent to all budget holders with instructions.	Finance, People and Performance Committee Non – Pay Review meeting	Monthly review Weekly	Clinical Chief of Finance	Inadequate	Monthly review
Established Financial Turnaround with operational support unit (OSU)	Finance, People and Performance Committee	Monthly review	Clinical Chief of Finance	Inadequate	Weekly review
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	
Risk assigned to:	Chief Financial Officer	Signed	Spencer Prosser	Date	March 2016

To be agreed by Trust Board

Risk Appetite	Impact	5	Likelihood	2	Severity	10	Significant

Justification for Risk: The consequence of not meeting financial targets will always be extreme. Due to current financial climate unable to reduce the likelihood of the risk occurring of below unlikely. This will always remain a significant risk but need to ensure adequate controls are in place to mitigate the risk where possible.

Ref:8	**Objective: Excellent outcomes Great Experience**	**Fundamental : Modern Estate**	**Assurance Committee**	**Finance, People and Performance Committee**
Ref: 5 BAF 15/16	**Risk Description**	**Staff and patients may be put at risk from failure to maintain adequately the estate, equipment and facilities management services**		
Cause (What might cause the risk to occur?)	• Inability to monitor and improve service performance for soft Facilities Management (FM) • Backlog maintenance • Training competence • Contractor performance			
Consequences (What are the possible consequences if the risk occurs?)	• Impact on patient experience • Risk of action from statutory bodies e.g. CQC, Fire & Rescue Service, Health & Safety Executive. • Reputational issue quality of Facilities Management.			
Risk Owner	Chief Finanical Officer			

Initial Risk Rating	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity	16	HIGH

Existing Controls (What existing processes / controls are in place to manage the risk?)	• A full 6 facet survey of the Estate has been completed to inform the revised Estates Strategy and update the quantum of backlog maintenance and the level of risk inherent therein. • Annual PLACE inspections to provide additional assurance. • Action plans and risk assessments available for Fire and other key issues e.g. Asbestos, Safe Water Management. • Action plan in place and committees monitor water management issues effectively. Additional advice to resolve persistent water safety issues from expert in water management issues. • CQC visit action plan • Clear line reporting from H&S committee to FPC and Trust Board. • Appointed substantive Director of Facilities & Estates

Current Risk Rating	Current Impact	4	Current Likelihood	4	Current Severity	16↔	HIGH

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Mobilisation complete to bring Facilities Management back in house on 1st September 2015. Improving compliance oversight & Hotel services now back in house.	Operational meetings Contract performance monitoring meetings PLACE & CQC inspection	Daily Monthly	DofF&E Clinical Director Facilities and Estates	Adequate	Measures are on-going and issues are still being resolved. There are weekly project reports and weekly project meetings.
Review and implementation of Waste management Plan and procedures for Trust. This requires review of waste management contractor and updated information and guidance to staff.	Waste Management Steering Group Health and Safety Committee Finance, People and Performance Committee	Bi Weekly Bi Monthly Bi Monthly	DofF&E Clinical Director Facilities and Estates	Inadequate	Bi weekly review
Estate Strategy will become part of the Sustainability and Transformation 5 year plan which will be Sussex-wide. . Ensuring implemented Maintenance KPI's – out for comment to Estates team Feb 2016. Sustainability Development Plan (carbon Management plan replacement) to April FPPC with Financials	Finance, People and Performance Committee Performance review	Monthly	CEO DF&E Assistant Director of 3T's	Inadequate	July 2016 April 2016 April 2016
Hydrop independent specialist audit regarding water management report action plan being implemented and reviewed by WMC. This will be re audited by March 2016. L8 Software being rolled out though departments	Water Safety action meeting. Water Management Committee and Health and Safety Committee	Monthly Monthly Bi-monthly	Chief Nurse and DIPC Chief Financial Officer	Adequate	Monthly review

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Implement action plans for management of *Pseudomonas Aureginosa* and other water Safety issues by completing Clinical Risk assessment linked to Water Safety Plan and actions reviewed at the Water Management Committee.	Water Safety action meeting. Water Management Committee and Health and Safety Committee	Monthly Monthly Bi-monthly	Chief Nurse and DIPC Chief Financial Officer	Adequate	Review Monthly
Re-appoint Chair of Water Safety Committee to ensure Executive support.	Water Management Committee	Monthly	Chief Nurse and DIPC Chief Financial Officer	Adequate	Review Monthly
Ensure action plans re: statutory compliance re H&S and Fire Safety concerns relating to Facilities and Estate especially following statutory body visits are being implemented and escalated if any delay to the Executive lead and /or assurance committee. Lead executive and reporting structure in place.	Health and Safety Committee reporting Finance, People and Performance Committee	Bi Monthly	Interim ODF&E Director of Corporate Affairs and Company Secretary	Adequate	Bi monthly review
BSUH Hospital sites will have no capacity during the 3t's development period to decant a clinical area if require to carryout remedial, development or backlog works such as laying new floor etc.	Finance, People and Performance Committee	Bi-monthly	Chief Financial Officer DofF&E	Inadequate	
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	

Risk assigned to:	Chief Finanical Officer	**Signed**	Spencer Prosser	**Date**	March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	3	**Likelihood**	3	**Severity**	9	Significant

Justification for Risk Appetite: Agreed revised estates strategy will provide prioritisation for future investment given known resource and ongoing Capital Investiment Programs. Also need continued review of Facilities Management Services improvements which will take time to embedd.

Ref:9	**Objective**	**Excellent outcomes Great experience Empowered, skilled staff High productivity**	**Assurance Committee**	**Finance, People and Performance Committee**
BAF 15/ 16	**Risk Description**	**Inability to deliver consistently large scale business change**		
Cause (What might cause the risk to occur?)	• Inconsistent alignement of change programmes with Trust strategy and priorities • No central oversight of all change activities • Limited prioritisation and excessive number of change projects • Limited capacity and capability to undertake change • Trust wide initiatives not seen as a “must do” therefore only implemented on a user acceptance level • Planning rushed with consequential impact on delivery • Poor lines of accountability and responsibility			
Consequences (What are the possible consequences if the risk occurs?)	• Loss of business case benefits – financial and qualitative • Delays in project implementation • Added cost through Projects and Programmes taking longer to deliver • Staff engagement limited • Decision making ineffective • No knowledge management for lessons learned			
Risk Owner	Director of People			

Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity (Impact X likelihood)	16	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Current PRINCE2 and MSP standards already in place for most projects/programmes although could be improved • No Trust wide controls in place to address this risk although is recognised • Programme Boards in place for EPR and 3Ts • Change Board established

Current Risk	Current Impact	4	Current Likelihood	4	Current Severity	16 ↔	High

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Embedding of Change Board (Change Initiative Assessment Group)	Change Initiative Assessment Group Finance, People and Performance Committee	Monthly Bi-monthly	Deputy Chief Executive	Adequate	Change Initiative Assessment Group in place
Creation of Integrated Change Team through phase 2 of Operational Support Unit	Change Board Finance, People and Performance Committee	Monthly Bi-monthly	Deputy Chief Executive	Inadequate	Phase 2 of Turnaround recovery will create an integrated change team in December 2015

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate			
Risk assigned to:	Director of People	Signed	Brendan Ward		Date	Feb 2015	

To be agreed by Trust Board

Risk Appetite	Impact	2	Likelihood	2	Severity	4	Moderate

Justification for risk appetite In the gift of trust to manage changes processes but relies on the correct resources and people to be engaged within realistic timescales.

Ref: 10	Objective	Excellent outcomes Great experience	Assurance Committee	Finance, People and Performance Committee
Ref: 2015/16	**Risk Description**	**Ability of the Trust and Local Health Economy partners to consistently deliver performance standards**		

Cause (What might cause the risk to occur?)	**Urgent care** • Higher than expected growth in emergency surgery and trauma activity partly as a result of the reconfiguration of services at East Sussex Healthcare Trust (ESHT) • Significant variation in daily attendances at the Royal Sussex County Hospital (RSCH) site, including ambuLance conveyances • High number of Medically Ready for Discharge patients • Increased demand in primary care • Shortage of physical capacity on the RSCH site **Scheduled care** • Insufficient capacity to keep pace with elective demand • Significant imbalance of four key specialties • Poor data quality • Inconsistent/incorrect application of Patient Access Policy						
Consequences (What are the possible consequences if the risk occurs?)	• Negative impact on patient safety and experience • Non-compliance with regulatory standards • Potential financial penalties • Organisational reputation • Patients wait too long for treatment with inefficient booking processes and significant rework • Limited access to Independent Sector. • Patients concerns about long waits but limited capacity within Sussex – either independent sector or other NHS Trusts to help. • Action from regulator (NTDA) for not achieving NHS constitution access targets • Commissioners applying contract penalties.						
Risk Owner	Chief Operating Officer						
Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely	4	Initial Severity	16	High

	5. Extreme		5. Almost certain				

Existing Controls (What existing processes / controls are in place to manage the risk?)	**Unscheduled care** • On-going programme of work which has included investment in senior decision making in the emergency departments (EDs); redesign of on call arrangements; Hospital Rapid Discharge Team (HRDT); improved use of space within EDs; changes to medical rota; direct admissions to AMU • Operational Delivery Team led by interim Associate Director of Operations for Medicine • Patient flow and escalation policy • Cohorting policy • Capacity Management System to support daily management of capacity and flow across Sussex & Surrey • On-going work to develop primary care and other alternatives to ED attendance • Work with community providers to review nursing home capacity to improve access and response times of community services • Daily support from SECAmb to enable ambulance diverts as required, and scrutiny of conveyances **Scheduled care** • Patient Access Policy • Twice weekly RTT meeting • Weekly speciality meetings to review patients waiting for treatment and patients are dated according to clinical priority and time on list • Engaging IST and working closely with CCG's						
Current Risk	Current Impact	4	Current Likelihood	5	Current Severity	20 ↔	High

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Emergency Care Intensive Support Team (ECIST) whole system review with the Trust, commissioners and other providers to advise on further improvement to our current systems	Bed state and Discharge meetings ECIST action Plan and 5 work streams	Daily Weekly	Chief Operating Officer	Adequate	Weekly review until complete
Ensuring better alignment of senior clinical workforce to periods of peak demand -	Clinical Management Board Quality and Risk	Monthly B- Monthly	Medical Director / Chief Operating Officer	Adequate	Monthly review until complete

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Continued focus on discharging patients earlier in the day	Bed state and Discharge meetings Clinical Management Board	Daily Monthly	Chief Operating Officer	Inadequate	Monthly review until complete
Increasing the proportion of patients that are discharged to their usual place of residence	Bed state and Discharge meetings	Daily	Head of Nursing for Discharge and Partnership	Inadequate	Monthly review until complete
Increasing operational control over the filling of bank nursing shifts to maintain staffing levels (Cross reference to risk : 9 BAF 2014/15)	Clinical Management Board	Monthly	Chief Nurse Deputy Chief Nurse	Inadequate	Monthly review until complete
Implementation of level 5 plan	Clinical Management Board Board of Directors	Monthly	Chief Operating Officer & Clinical Director (Acute Floor)	Adequate	Monthly report to Finance, People and Performance Committee and Board
Phased roll out of *Right Care, Right Place, Each Time* programme	Urgent Care Programme Board	Monthly	Deputy Chief Executive	Adequate	Monthly review of progress
Strengthen governance and performance management of RTT	Clinical Management Board and Executive Management Team	Bi Monthly	Deputy COO Planned Care	Inadequate	Weekly review until complete
Balance capacity and demand across four key high risk areas	Clinical Management Board and Executive Management Team	Bi Monthly	Deputy COO Planned Care	Inadequate	Weekly review until complete
Improve efficiency and minimise reliance in Independent Sector	Clinical Management Board and Executive Management Team	Bi Monthly	Deputy COO Planned Care	Inadequate	Weekly review until complete
Fully implement Patient Access Policy	Clinical Management Board and Executive Management Team	Bi Monthly	Deputy COO Planned Care	Inadequate	Bi-Monthly review until complete
Finish the work started to ensure we do not have patients with 18W clock running who are not actually waiting for anything	Clinical Management Board and Executive Management Team	Bi Monthly	Deputy COO Planned Care	Inadequate	Bi-Monthly review until complete

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Implement actions arising from audit of data quality	Executive Management Team	Bi Monthly	Associate Director Business Support	Adequate	Bi-Monthly review until complete

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control	Inadequate

Risk assigned to:	Chief Operating Officer	Signed	Mark Smith	Date	March 2016

To be agreed by Trust Board

Risk Appetite	Impact	4	Likelihood	2	Severity	8	Significant

Justification for risk appetite: When CQC and clinical restructure is fully embedded as a control rather than action likelihood could be reduced due to the level of control. There will always be an impact if patient does not receive appropriate care impacted by operational pressures. Therefore realistically the Trust would like to aim to unlikely. Rare would be an aspiration but currently not likely to achieve. Effective processes, controls and assurances in place but need to ensure not complacent.

Ref: 11	**Objective**	**Culture of Quality Performance Targets**	**Assurance Committee**	**Finance, People and Performance Committee**
BAF 15 /16	**Risk Description**	**Poor data quality may have adverse impact on planning, delivery and assurance**		

Cause (What might cause the risk to occur?)	• Multiple systems which are not interfaced to the spine • Inadequate capacity, training and supervision of system users. • Inconsistent or lack of ownership of information and service/department level
Consequences (What are the possible consequences if the risk occurs?)	• Efficiency Savings cannot be achieved/demonstrated • Failure of service changes - inability to control costs • In ability to develop future plans based on data and information that is not robust • Inability to provide assurance internally and externally
Risk Owner	Chief Financial Officer

Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	3	Initial Severity	12	Significant

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Information Governance Tool-kit – reviewed by Information Governance Committee routinely with assurance to Audit Committee • Information Governance Tool-kit action plan to address weakness through IG committee. • Information Governance committee – refreshed and chair, Director of Health Informatics • Information Events e.g. provided by National Archive – inform key personnel of their responsibilities. • Spot check DQ audits – mandatory annual audits (internal audit tracker as part of annual audit plan as agenda item at Audit Committee). Also extend PSR (payment by results) Audit. • Monthly/quarterly 'clean-up' of externally submitted corporate data • Routine monitoring by corporate information of PAS/SUS related data quality for CDSs • Centralisation of Admin and Clerical staff to enable consistent working practices across the Trust. This is linked to the Hub project. • Coding work stream facilitates improvement in both data and information quality. Supported by focused action plans managed by Clinical Coding Performance Manager • Service Line Management programme identifies service specific issues including data/information quality.

	Identified issues are then included in SLM action plans and delivery monitored through reporting in SLM Blue Book (supported by SLM Project Manager) • Trust submission of NHS TDA reports. • Develop plan for re-provision of data warehouse – as part of Information Management Strategy • HR Dashboard in place with data monthly review relating key HR themes to recruitment, retention, exit interviews etc.						
Current Risk	Current Impact	4	Current Likelihood	3	Current Severity	12	Significant

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Complete actions from gap analysis following IG toolkit submission	Information Governance committee	Quarterly	Gareth Hall	Adequate	March 2016
Delivery of objectives within Information Management Strategy accompanied by establishment of steering group to oversee action plan to improve access to and management of information	Strategy Implementation Plan Audit Committee	Monthly Quarterly	Gareth Hall/	Adequate	New Board and ToR in Place
Clinical Structure: Programme Delivery Manager incorporated clear Information and IG responsibilities in new management structures	Information Management Strategy Programme Board Workforce Plan and Training elements	6 Weekly	Ian Arbuthnot	Inadequate	On-going
Small restructure of Central Information Unit – now specific training role.	Information Management Strategy Programme Board	6 Weekly	Gareth Hall	Adequate	On-going
The Trust has developed a Data Quality Improvement Plan (DQIP) of which delivery will be monitored via the Information Management Strategy Programme Board; this will aim to improve the quality of both internally and externally reported	Information Management Strategy Programme Board	6 Weekly	Gareth Hall	Inadequate	On-going

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
data.					
Re-provision of IG Training – As part of IG work plan. A Virtual Learning Information and IG training module in place on IRIS	Information Governance Committee	6 Weekly	Ian Arbuthnot	Adequate	Monthly review of access to IG training as part of mandatory training.
Follow up actions to Data Quality Audit with Data Quality Patient Journey to clearly identify from initiation to final reporting externally. To inform an action plan to improve better collection of data and information at all stages to include: focused training, standard operating procedures	Information Management Strategy Programme Board	6 weekly	Ian Arbuthnot	Inadequate	On-going
Establishment of Clinical Chief Information Officer – formal work plan to be advised.	Information Governance Committee	6 weekly	Heather Brown	Inadequate	On-going
Review and re-provision of Trust reporting solutions i.e. data warehouse	Data warehouse project board	TBC	Spencer Prosser	Inadequate	Scoping with procurement
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				1. Adequate	
Risk assigned to:	Chief Financial Officer	Signed	Spencer Prosser	Date	Feb 2015

To be agreed by Trust Board

Risk Appetite	**Impact**	**4**	**Likelihood**	2	**Severity**	8	Significant

Justification for Risk Appetite: Only significant reduction can be achieved when the IT infrastructure and EPR are upgraded. Current infrastructure is not robust enough to reduce likelihood. The important is to maintain an adequate level of control**.**

				Inadequate	Bi weekly review

				Inadequate	July 2016 April 2016 April 2016
				Adequate	Monthly review
				Inadequate	Review Monthly
				Inadequate	Review Monthly
Ensure action plans re: statutory compliance re H&S and Fire Safety concerns relating to Facilities and Estate especially following statutory body visits are being implemented and escalated if any delay to the Executive lead and /or assurance committee. Lead executive and reporting structure in place.	Health and Safety Committee reporting Finance, People and Performance Committee	Bi Monthly	Interim ODF&E Director of Corporate Affairs and Company Secretary	Adequate	Bi monthly review
BSUH Hospital sites will have no capacity during the 3t's development period to decant a clinical area if require to carryout remedial, development or backlog works such as laying new floor etc.	Finance, People and Performance Committee	Bi-monthly	Chief Financial Officer DofF&E	Inadequate	
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	

Risk assigned to:	Chief Finanical Officer	**Signed**	Spencer Prosser	**Date**	Feb 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	3	**Likelihood**	3	**Severity**	9	Significant

Justification for Risk Appetite: Agreed revised estates strategy will provide prioritisation for future investment given known resource and ongoing Capital Investiment Programs. Also need continued review of Facilities Management Services improvements which will take time to embed

Datix Ref:		**Objective** **1) Empowered, skilled staff** **2) Excellent outcomes** **3) Great experience** **4) High productivity**	**Assurance Committee**	**Finance, People and Performance Committee**
Ref: BAF 15/ 16	**Risk Description**	**Leadership and management – capability and accountability**		

Cause (What might cause the risk to occur?)	• Leadership and management resource strategy is inadequate • Significant number of senior leadership vacancies either vacant or being filled by interims • No PMO function • Performance management is limited and sanctions not applied • Perceived 'optional' approach to Trust programmes • Appraisals currently not linked to business plan • No shared understanding of strategic direction • Corporate functions not aligned to clinical directorates
Consequences (What are the possible consequences if the risk occurs?)	• Negative impact on operational performance, financial management, service improvement, delivery of Trust programmes • Poor staff engagement
Risk Owner	Medical Director, Director of People and Chief Nurse

Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity (Impact X likelihood)	16	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• A disease based clinical lead structure introduced in September 2014 • Leading the Way and Leading the Way Too Programmes • Improved appraisal rates						
Current Risk	Current Impact	4	Current Likelihood	4	Current Severity	16	**High**

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Clearly aligned strategy that links to 2016/17 business plan	Executive Management Team People Committee	Bi-monthly	Deputy Chief Executive	Inadequate	May 2016
Values based recruitment and selection process	Executive Management Team People Committee	Bi-monthly	Director of People	Inadequate	September 2016
BSUH 'Clinical Compact'	Executive Management Team People Committee	Bi-monthly	Medical Director	Inadequate	September 2016
Bespoke leadership programme for clinical leaders	Executive Management Team People Committee	Bi-monthly	Medical Director	Inadequate	May 2016
Implementation of talent management and succession planning processes	Executive Management Team People Committee	Bi-monthly	Director of People	Inadequate	September 2016
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control				Inadequate	
Risk assigned to:	Medical Director, Director of People and Chief Nurse	Signed	Dr Steve Holmberg Helen Weatherill Sherree Fagge	Date	March 2016

To be agreed by Trust Board

Risk Appetite	Impact	3	Likelihood	3	Severity	9	Significant
Justification for risk appetite							

Datix Ref:		**Objective** **5) Empowered, skilled staff** **6) Excellent outcomes** **7) Great experience** **8) High productivity**	**Assurance Committee**	**Finance, People and Performance Committee**
Ref: BAF 15/ 16	**Risk Description**	**Low levels of staff engagement**		

Cause (What might cause the risk to occur?)	• No long-term leadership at the top • No shared vision and strategic direction with staff • No leadership strategy • No agreed staff engagement methodology • Staff not able to do their jobs because of operational pressures and/or lack of equipment • Appraisal rates below target • Work-related stress, pressures and support • Access to training, development and opportunities for career progression • Clinical Directorate and corporate functions not sufficiently aligned						
Consequences (What are the possible consequences if the risk occurs?)	• Negative impact on staff morale, team-working, patient experience, operational performance, financial management, service improvement and delivery of Trust programmes						
Risk Owner	Medical Director, Director of People and Chief Nurse						
Initial Risk (should be significant and above rated risk)	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	5	Initial Severity (Impact X likelihood)	20	High

Existing Controls (What existing processes / controls are in place to manage the risk?)	• Clinical Structure (clinically-led Directorates) • Values and Behaviours Programme • People and Well-Being Strategy and Implementation Plan • Clinically-led Services Change • Staff Forums e.g. Staff Council, Medical Advisory Committee

	• Staff Communications						
Current Risk	Current Impact	4	Current Likelihood	4	Current Severity	16	**High**

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Vision and priorities	Board of Directors	Quarterly	Chief Executive	Inadequate	May 2016
Leadership strategy	Executive Management Team People Committee	Six-monthly	Chief Executive	Inadequate	May 2016
Well-being programme of work including stress, bullying and harassment, violence from patients	Executive Management Team People Committee	Bi-monthly	Director of People	Adequate	April 2016
Implementation of appraisal cycle and access for staff to training and development (including ST&M)	Executive Management Team People Committee	Bi-monthly	Director of People	Inadequate	April 2016
Continue to review staffing and vacancies	Executive Management Team People Committee	Bi-monthly	Director of People	Adequate	April 2016
Internal communications strategy (including team brief)	Executive Management Team People Committee	Bi-monthly	Director of Communications	Adequate	
Implementation of Medical Engagement, Leadership and Talent Management Plan	Executive Management Team People Committee	Bi-monthly	Medical Director	Inadequate	April 2016

BSUH 'Clinical Compact'	Executive Management Team People Committee	Bi-monthly	Medical Director	Inadequate	

Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control					
Risk assigned to:	Director of People	Signed	Helen Weatherill	Date	March 2016

To be agreed by Trust Board

Risk Appetite	**Impact**	**3**	**Likelihood**	**3**	**Severity**	**9**	**Significant**
Justification for risk appetite							