BSUH Board Assurance Framework 2015 /2016 – Quarter 2 19/11/2015

New risk	Ref BAF	Risk Description	Exec lead	Trust Objective / Fundamental	Current Risk Rating	Movement from Last Review	Lead Assurance Committee	Datix ref	Page of Report
Board of Directors									
New	1	Failure to deliver the required changes in capacity to support achievement of key access targets, quality of care, patient and staff experience	Deputy Chief Executive	Aligning capacity and demand	16	↔	Board of Directors		4
Existing	2	200 year old clinical infrastructure at RSCH and 75 years old infrastructure at HWP which is no longer fit for purpose. Failure to obtain approval FBC for 3t's development or delayed further will affect long term management.	Deputy Chief Executive (Director of 3Ts)	All corporate objectives Site reconfiguration Modern estate - 3Ts	15	↔	Board of Directors		6
Quality and Risk Committee									
New	3	Non-compliance with regulatory standards and statutory duties leading to regulatory or enforcement action	Chief Nurse (Safety & Quality); Deputy Chief Executive (Equality); Director of Health Informatics (Information Governance);	Excellent outcomes Great experience	20	↔	Quality and Risk Committee		8

BSUH Board Assurance Framework 2015 /2016 – Quarter 2 19/11/2015

New risk	Ref BAF	Risk Description	Exec lead	Trust Objective / Fundamental	Current Risk Rating	Movement from Last Review	Lead Assurance Committee	Datix ref	Page of Report
New	4	Adverse outcomes and experience for patients arising from poor patient flow	Chief Operating Officer	Excellent outcomes Great experience	20	↔	Quality and Risk Committee		12
Existing	5	Failure to ensure that there is enough suitably qualified, skilled and experienced staff to meet the needs of all patients across all services.	Medical Director & Chief Nurse	Excellent outcomes Great experience Empowered & skilled staff	20	↔	Quality and Risk Committee	1345/ 1354	14
New	6	Inadequacy of whistle-blowing arrangements inhibits development of learning and improvement culture	Deputy Chief Executive	Excellent outcomes Great experience	16	↔	Quality and Risk Committee		17
Finance, People and Performance Committee									
Existing	7	Inability to deliver financial plan	Chief Financial Officer	High productivity	20	↔	Finance, People and Performance Committee	1352	19
Existing	8	Staff and patients may be put at risk from failure to maintain adequately the estate, equipment and facilities management services	Chief Financial Officer	Excellent outcomes Great experience Modern estate	16	↔	Finance, People and Performance Committee	1350	22

BSUH Board Assurance Framework 2015 /2016 – Quarter 2 19/11/2015

New risk	Ref BAF	Risk Description	Exec lead	Trust Objective / Fundamental	Current Risk Rating	Movement from Last Review	Lead Assurance Committee	Datix ref	Page of Report
New	9	Inability to deliver consistently large scale business change	Deputy Chief Executive	Excellent outcomes Great experience Empowered, skilled staff	16	↔	Finance, People and Performance Committee		26
Existing	10	Ability of the Trust and Local Health Economy partners to consistently deliver performance standards	Chief Operating Officer	Great experience	20	↔	Finance, People and Performance Committee	1354, 1359 12	28
Existing	11	Poor data quality may have adverse impact on planning, delivery and assurance	Chief Financial Officer	Top productivity	12	↔	Finance, People and Performance Committee	1347	32

BSUH Board Assurance Framework 2015 /2016 – Quarter 2 19/11/2015

<table>
<tr><td>Ref: 1</td><td>Fundamental</td><td colspan="5">Aligning capacity and demand</td><td>Assurance Committee</td><td colspan="2">Board of Directors</td></tr>
<tr><td>BAF 15/16</td><td>Risk Description</td><td colspan="8">Failure to deliver the required changes in capacity to support achievement of key access targets, quality of care, patient and staff experience</td></tr>
<tr><td colspan="2">Cause (What might cause the risk to occur?)</td><td colspan="8">• Bed occupancy has increased from 91.4% in 2011/12 to 93.4% in 2014/15.
• Acute bedded capacity has declined by approximately 40 beds although this has been offset by the the use of a higher number of escalation beds in 2014/15.
• Physically, there is limited if any 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 exist in each community unit are factors with regard to the use of community beds and their availability and utilisation
• Fragmentation of pathways across the system with multiple hand-offs,
• During 2014/15 activity increased by 3.4%;
• NEL short-stay activity (<1 day average length of stay) declined markedly from 2012/13, with admission avoidance schemes in Brighton and Hove in particular appearing to have increasing effect. The remaining NEL activity has been stable, but with increasing average lengths of stay,</td></tr>
<tr><td colspan="2">Consequences (What are the possible consequences if the risk occurs?)</td><td colspan="8">• 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) awaiting onward transfer to home or alternative care setting
• Increased number of sub-acute patients occupying acute beds
• Negative impact on patient safety and experience and non-complaince 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</td></tr>
<tr><td colspan="2">Risk Owner</td><td colspan="8">Deputy Chief Executive</td></tr>
<tr><td colspan="2">Initial Risk (should be significant and above rated risk)</td><td>Initial Impact
1. Insignificant
2. Minor
3. Moderate
4. Major
5. Extreme</td><td>4</td><td>Initial Likelihood
1. Rare
2. Unlikely
3. Possible
4. Likely
5. Almost certain</td><td>4</td><td>Initial Severity
(Impact X likelihood)</td><td>16</td><td colspan="2">High</td></tr>
</table>

<table>
<tr><td colspan="2">Existing Controls (What existing processes / controls are in place to manage the risk?)</td><td colspan="6">• Capacity Mobilisation Group oversees delivery of agreed programmes including;
➢ Overall monitoring of agreed planned changes in required capacity
➢ Development 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</td></tr>
<tr><td>Current Risk</td><td>Current Impact</td><td>4</td><td>Current Likelihood</td><td>4</td><td>Current Severity</td><td>16↔</td><td>High</td></tr>
</table>

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	Deputy Chief Executive	Adequate	Implementation commenced October 2015, completed by December 2015
Phased roll out of *Right Care, Right Place, Each Time* programme	Urgent Care Programme Board	Monthly	Deputy Chief Executive	Adequate	Roll out commenced in August – to be completed by end of Q3
Ensure extra capacity planned (Newhaven, Hospital at Home, Plumpton) comes on stream	Capacity Mobilisation Group	Fortnightly	Deputy Chief Executive	Adequate	Newhaven & Plumpton open in November 2015, Hospital at Home in Q4
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:	Deputy Chief Executive	Signed	Amanda Fadero	Date	November 2015

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. Failure to obtain approval FBC for 3Ts development or delayed further will affect long term management.

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	Regular reports to 3Ts Programme Board, CMB and Board.	Monthly	Duane Passman, Director of 3Ts	Adequate	Completed and on-going
Approval required for FBC from HM	Regular reports to 3Ts	Monthly	Duane Passman,	Adequate	February 2015

Treasury	Programme Board, CMB and Board		Director of 3Ts		
Business Case has been approved by TDA and HMT. Approval letter is to follow imminently. 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 delivery,	Monthly	Duane Passman, Director of 3Ts	Adequate	Monthly review
National Programme Board constituted to manage FBC approval process. First meeting of Working Group 24 July 2014. First meeting of Programme Board 8 August 2014.	Monthly meeting, with an associated National Working Group	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:	Deputy Chief Executive (Director of 3T's)	Signed	Amanda Fadero Duane Passman	Date	November 2015

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 appraisal and 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 (Safety & Quality); Deputy Chief Executive (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 • 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 policies, procedures, governances. Annual Water Safety Audit and separate specialist advice. Annual and interim report on water safety issues. • Health and Safety and Fire Safety Professional advice, Bi monthly committees and policies / procedures with annual report and Bi annual Audit. H&S committee has Staff side representation and report son key trends and key safety issues in Trust. • Annual and interim reports for Finance, People and Performance Committee on Health and Safety and Fire Safety. • Annual internal audit of Risk Management arrangements. • 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**
Baseline assessment of CQC fundamental standards. Meeting with Directorates Quarterly to Safety and Quality Governance	Clinical Management Board Quality and Risk Committee	Quarterly	Associate Director of Quality	Inadequate	Quarterly meeting review
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	People Board	Monthly	Operational Director of HR	Inadequate	Ongoing with regular improvement

format for appraisal in place with training provided.	Finance, People and Performance Committee	Monthly			
Agreement of framework and infrastructure to manage IG and security risks.	Executive Team	Monthly	Director of Health Informatics	Adequate	Bi-monthly review
Procurement to ensure that all contracts legally permissible. Tendering and ongoing monitoring processes ensure that due regard is given to all protected characteristics	Finance, People and Performance Committee	Monthly	Chief Procurement Officer	Inadequate	Monthly review
Board to ensure that all their decisions fully take into account due regard for all protected characteristics with relevant evidence	Board of Directors	Bi-Monthly	Deputy Chief Executive	Inadequate	Monthly review
Due regard – all policies, services and changes to functions are subjected to evidence based due regard that is reflected throughout the policy/document.	Executive Team	Monthly	Deputy Chief Executive	Inadequate	On-going with regular improvement
On-going governance and assurance. All governance committees take an active role in monitoring performance of policy/services etc. Providing routine evidence to the Board with evidence based recommendations	Executive Team	Monthly	Deputy Chief Executive	Adequate	September 2015
Water Safety arrangements suitable and sufficient with suitable	Finance, People and	Monthly	Chief Financial Officer and Chief	Adequate	Monthly review

Assurance arrangements.	Performance Committee		Nurse		
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	Inadequate	Bi Monthly review
Improved management and control of waste, updating information to staff, and policy and procedures.	Health and Safety Committee	Bi-monthly	Chief Financial Officer and Chief Nurse	Inadequate	Bi 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 Nurse (Safety & Quality); Deputy Chief Executive (Equality); Director of Health Informatics (Information Governance);	Signed		Date	November 2015

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 (Medical Director & 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?)	• 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
Ten high impact change programmes	Clinical Management Board Board of Directors	Monthly	Deputy Chief Executive	Inadequate	Quarterly report to Board as part of progress report on Annual Plan
RTT recovery plan	Clinical Management Board Board of Directors	Monthly	Chief Operating Officer (Director of Scheduled Care and Service Transformation)	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	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:	Chief Operating Officer	Signed	Mark Smith	Date	November 2015

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 Impact	4	Current Likelihood	5	Current Severity	20↔	High

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 strategy being developed to look at	Monthly and six monthly reports on safe staffing to Board of Directors	Monthly	Chief Nurse	Adequate	On-going and reported monthly
Strategies to recruitment in medical staffing, including action plans in challenged specialties but depends on medical staff being available. All specialities with concerns are identified and with actions to address these shortages.	Periodic reports from Medical Director to Quality and Risk Committee and Board of Directors Turnaround	As required Daily	Medical Director	Adequate	Controlling rather than resolving. January 2016
Growing the BSUH workforce in hard to recruit areas. This will be linked to the recruitment plan. This a specific issue in acute or some speciality. This was successful in intensive care and will be expanded	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
Leadership programme developed to roll out to all areas for Medical staff to	Safety & Quality review HR review	Monthly	Medical Director	Inadequate	On-going and reported monthly

and organisation development programme paper to Board of Directors in November as separate one off report which will need an action plan developed following this report.	Performance review				
Comprehensive end to end review of the recruitment process.	Finance, People and Performance Committee and Audit Committee	Bi Monthly	Operational Director of HR	Adequate	Further report to Audit Committee in September 2015
Self-assessment against 7 day supply 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	Clinical Management Board Board of Directors	Bi-monthly	Medical Director	Adequate	Gaps have been 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	November 2015

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	Deputy Chief Executive					
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	Operational Director of HR	Inadequate	October 2015

Implementation of revised whistle-blowing framework and appointment to roles to support this framework	Finance, People and Performance Committee Quality and Risk Committee	Quarterly	Operational Director of HR	Inadequate	November 2015
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	Operational Director of HR	Inadequate	November 2015
Development of process for recording all formal reports of incidents and concerns	Finance, People and Performance Committee Quality and Risk Committee l	Quarterly	Operational Director of HR	Inadequate	November 2015

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 Strategy and Change	Signed	Amanda Fadero	Date	November 2015

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.

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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
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 2 19/11/2015

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.	Finance, People and Performance Committee	Monthly review	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	November 2015

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	4	Current	4	Current	16↔	HIGH

	Impact		Likelihood		Severity		

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. This will require on-going actions following hand over to improve current arrangements and ensure patients are consistently cared for in a clean and hygienic environment. Improving compliance oversight & Hotel services now back in house.	Operational meetings Contract performance monitoring meetings CQC inspection There are weekly project reports and weekly project meetings so I am not sure where the effectiveness rating of inadequate has come from	Daily Monthly	DofF&E Clinical Director Facilities and Estates	Adequate	Measures are on-going and issues are still being resolved.
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
Approval Estate Strategy and KPI's – August 2015. Imbedding strategy and ensuring implemented	Performance review	Monthly	DofF&E	Inadequate	September 2015
Hydrop independent specialist audit re: water management report action plan being implemented and reviewed by WMC. This will be re audited by March 2016. Annual report provided to FPPC. Outstanding issue which is being addressed ensuring all	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
water outlets are regularly used. L8 Software being rolled out though departments					
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	Inadequate	Review Monthly
Re-appoint Chair of Water Safety Committee to ensure Executive support.	Water Management Committee	Monthly	Chief Nurse and DIPC Chief Financial Officer	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**	November 2015

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	Deputy Chief Executive					
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

BSUH Board Assurance Framework 2015 /2016 – Quarter 2 19/11/2015

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Embedding of Change Board	Change Board Finance, People and Performance Committee	Monthly Bi-monthly	Deputy Chief Executive	Adequate	Change Board and supporting infrastructure embedded from July 2015
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:	Deputy Chief Executive	Signed	Amanda Fadero	Date	November 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	December 2015
Strengthen governance and performance management	Clinical Management Board and Executive Management Board	Bi Monthly	Sally Howard as lead Director and Jo Andrews as Clinical Lead	Inadequate	Weekly review until complete
Balance capacity and demand across four key high risk areas	Clinical Management Board and Executive Management Board	Bi Monthly	Sally Howard as lead Director lead and Jo Andrews as Clinical Lead	Inadequate	Weekly review until complete
Improve efficiency and minimise reliance in IS	Clinical Management Board and Executive Management Board	Bi Monthly	Sally Howard as Director lead and Jo Andrews as	Inadequate	Weekly review until complete

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
			Clinical Lead		
Fully implement Patient Access Policy	Clinical Management Board and Executive Management Board	Bi Monthly	Sally Howard as Director lead and Jo Andrews as Clinical Lead	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 Board	Bi Monthly	Sally Howard as Director lead and Jo Andrews as Clinical Lead	Inadequate	Bi-Monthly review until complete
Audit of data quality	Clinical Management Board and Executive Management Board	Bi Monthly	Sally Howard as Director lead and Jo Andrews as Clinical Lead	Inadequate	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	November 2015

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 rom gap analysis following IG toolkit submission	Information Governance committee	Quarterly	Gareth Hall	Adequate	December 2014
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/James Weller	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 is being developed to replace the IG workbook.	Information Governance Committee	6 Weekly	Ian Arbuthnot	Inadequate	Revised 01/04/2015
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	November 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.