Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting

Meeting Date: Board Of Directors, 24 January 2018

Title and Author of Paper: Board Assurance Framework and Corporate Risk Register – Natalie Yeowart, Risk Management Lead.

Executive Lead: Lisa Quinn, Executive Director of Commissioning and Assurance

Paper for Debate, Decision or Information: Information

Key Points to Note:

Pg.1 There has been a reduction in BAF/CRR risks from 24 to 20.
Pg.3 Quality Effectiveness continues to be the highest risk appetite category on the BAF/CRR at six risks.
Pg.3 There are currently eight risks which exceeded a risk appetite on the BAF/CRR.
Pg.6 There are two risks to be de-escalated from the BAF/CRR to Chief Operating Officer.
Pg.7 Three risks were reviewed by the Deputy Chief Executive and a decision to merge with a current risk on the Board Assurance Framework/Corporate Risk Register has been made.
Pg.8-11 Risk Appetite has been implemented throughout Locality Care Group Risk Registers. Please note CBU levels will be reported in Q4.
Pg.13 Please note the Escalation to BAF/CRR request from Deputy Chief Executive.

Risks Highlighted:
As highlighted in the paper.

Does this affect any Board Assurance Framework/Corporate Risks?
Yes – Report detailing the review of the Board Assurance Framework and Corporate Risk Register.

Equal Opportunities, Legal and Other Implications:
Addressed in Board Assurance Framework and Corporate Risk Register

Outcome Required: To note Board Assurance Framework and Corporate Risk Register and Groups/Corporate Risks.

Link to Policies and Strategies:
Risk Management Strategy and Risk Management Policy

Northumberland, Tyne and Wear NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

Purpose

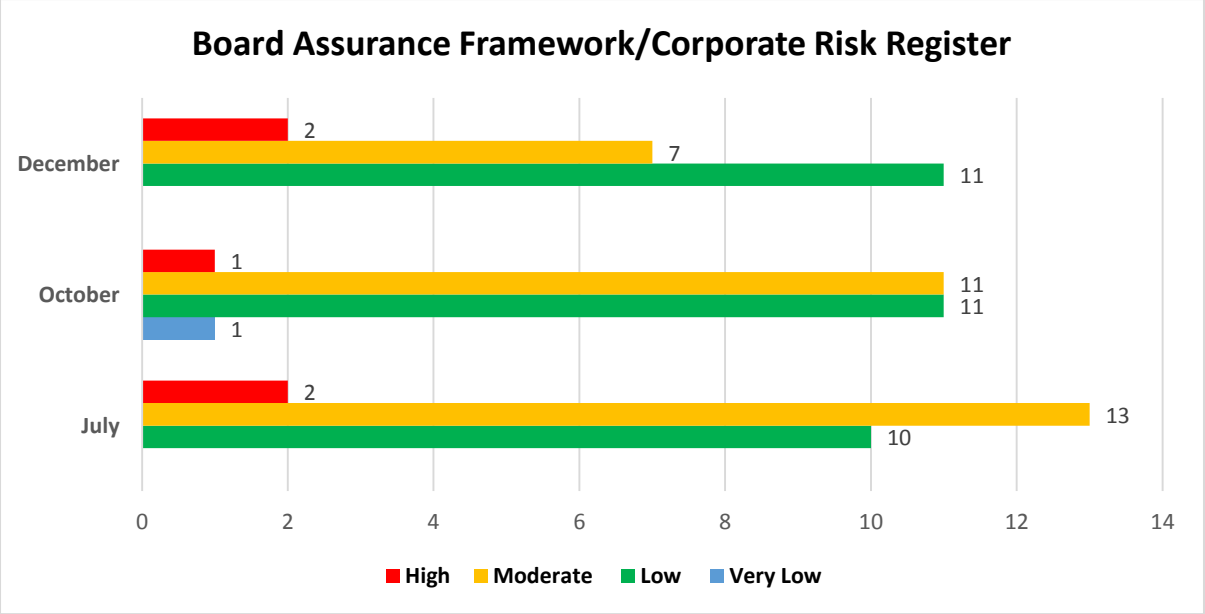
The Northumberland, Tyne & Wear NHS Foundation Trust Board Assurance Framework/Corporate Risk Register identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

This paper provides:

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- A detailed description of the risks which have exceeded a Risk Appetite included on the BAF/CRR, Locality Group and Corporate Directorate Risk Registers.
- A detailed description of any changes made to the BAF and CRR.
- A detailed description of any BAF/CRR reviewed and agreed risks to close.
- A summary of both the overall number and grade of risks held by each Clinical Group and Executive Corporate Risk Registers on the Safeguard system as at December 2017.

1.0 Board Assurance Framework and Corporate Risk Register

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at December 2017. In the quarter there has been a decrease in the overall number of risks from 24 to 20.

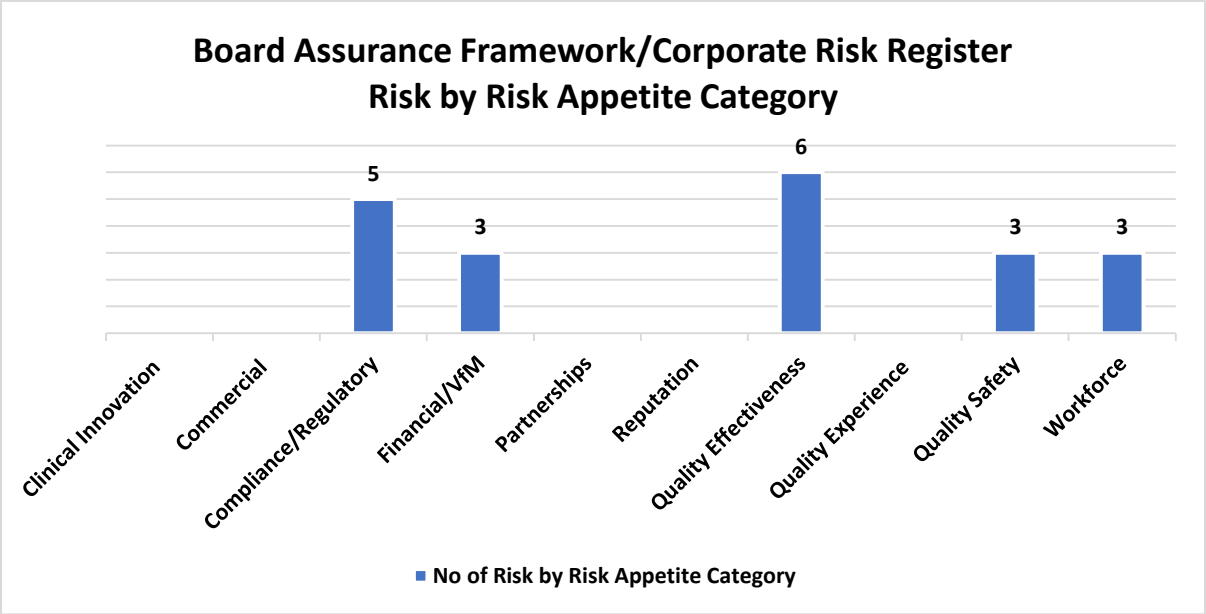


1.1. Risk Appetite

Risk Appetite is the level of risk the Trust Board deem acceptable or unacceptable based on specific risk categories and circumstances/situations facing the Trust. This allows the Trust to measure, monitor and adjust, as necessary the actual risk position against a risk appetite. The below table shows the risk appetite categories and risk appetite scores.

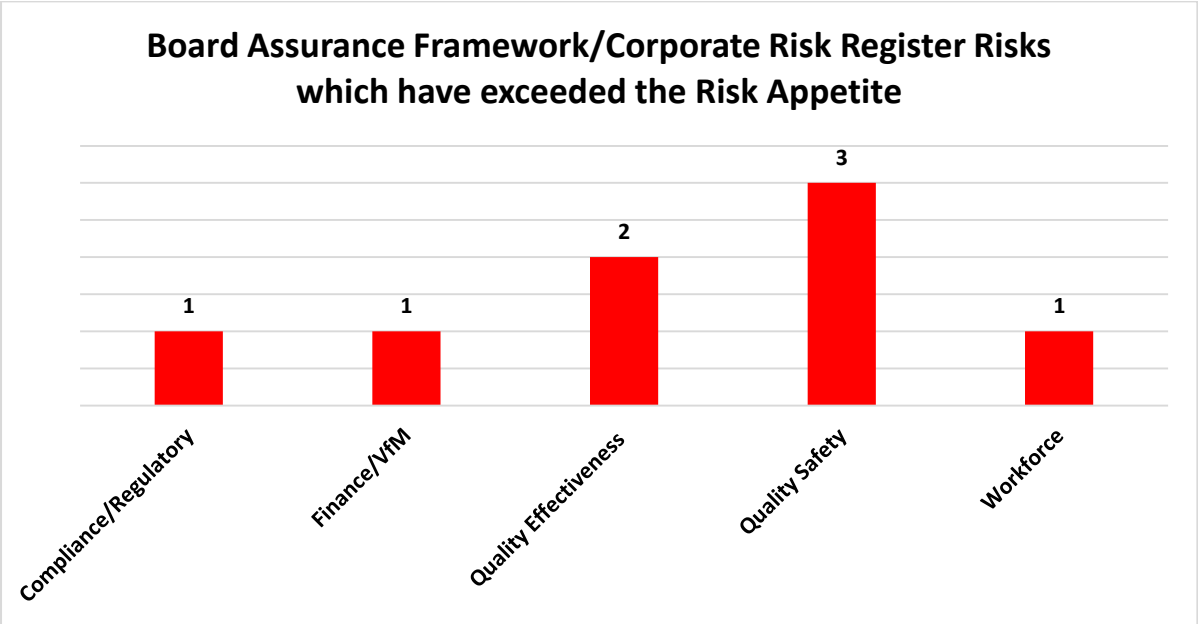
Category	**Risk Appetite**	**Risk Appetite Score**
Clinical Innovation	NTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care.	**12-16**
Commercial	NTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users.	**20-25**
Compliance/Regulatory	NTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial/Value for money	NTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimising the possibility of financial loss and comply with statutory requirements.	**12-16**
Partnerships	NTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve.	**20-25**
Reputation	NTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**12-16**
Quality Effectiveness	NTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality Experience	NTW has a **LOW** risk appetite for risks that may affect the experience of our service users.	**6-10**
Quality Safety	NTW has a **VERY LOW** risk appetite for risks that may compromise safety.	**1-5**
Workforce	NTW has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce.	**12-16**

Risk appetite was implemented throughout the Board Assurance Framework/Corporate Risk Register in April 2017. The below table shows risks by risk appetite category. The highest risk appetite category is Quality Effectiveness (6) which is defined as risk that may compromise the delivery of outcomes.



Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 8 risks which have exceeded a risk appetite tolerance in the quarter.

The table below shows all BAF/CRR risks which have exceeded a risk appetite tolerance.



A detailed description of each BAF/CRR risk which has exceeded a risk appetite can also be found below. Action plans are in place to ensure these risks are managed effectively.

Risk Reference	Risk description	Risk Appetite	Risk score	Executive Lead
SA1.4	The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are subsequently not sufficiently responsive to demands.	Quality Safety (1-5)	8	Gary O'Hare
SA3.1	That we do not further develop integrated information systems across partner organisations	Quality Safety (1-5)	9	Lisa Quinn
SA3.2	That we do not influence the development of new delivery models (ACO, MCP, ACS) leading to increasing fragmentation of MH service delivery.	Quality Effectiveness (6-10)	16	John Lawlor
SA4.1	That we have significant loss of income through competition and national policy including the possibility of losing large services and localities.	Finance/VfM (12-16)	20	James Duncan
SA4.3	That the scale of change and integration agenda across the NHS could affect the sustainability of services & Trust financial position.	Finance/VfM (12-16)	15	John Lawlor
SA5.2	That we do not meet significant statutory and legal requirements in relation to Mental Health Legislation	Compliance/ Regulatory (6-10)	12	Rajesh Nadkarni
SA5.5	That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Quality Safety (1-5)	10	Gary O'Hare
SA5.8	Failure to develop NTW Academy resulting in the lack of enhanced future nursing supply.	Workforce (12-16)	20	Gary O'Hare

1.2. Amendments

Following review of the BAF/CRR with each lead Executive Director/Directors, the following amendments have been made:

Risk Reference	Risk description	Amendment	Executive Lead
SA1.2	That restrictions on capital funding nationally lead to a failure to meet our aim to achieve first class environments to support care, increasing the risk of harm to patients through continuing use of sub-optimal environments.	Risk amended to include PFI risk no SA1.6.	James Duncan
SA1.3	That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in commissioning of services.	Timescales amended, residual risk score increased from 4x2(8) to 4x3(12)	Lisa Quinn
SA1.6	Lack of ownership of PFI buildings. Restrictions in contract hinder ability to develop estate.	Risk merged with SA1.2.	James Duncan
SA1.7	That staff do not follow Information Governance, Caldicott and Informatics Policies and procedures.	Assurances added.	Lisa Quinn
SA1.8	Failure to participate and influence STP workforce developments may reduce our control over future regional workforce changes.	Minor language changes to control no: 3.	Lisa Crichton-Jones
SA3.1	That we do not further develop integrated information systems across partner organisations.	Gaps in control/action no.2 timescales amended.	Lisa Quinn
SA3.2	That we do not influence the development of new care delivery models (ACO, MCP, ACS) leading to increasing fragmentation of MH service delivery.	Gaps in control/actions added.	John Lawlor
SA3.4	NTW being marginalised in STP leading to impact on integration agenda.	Risk merged with SA3.2	James Duncan
SA4.1	That we have significant loss of income through competition, choice and national policy, including the possibility of losing large services & localities.	Residual risk score increased from 5x3(15) to 5x4(20). Gaps in control/actions added.	James Duncan
Risk	**Risk description**	**Amendment**	**Executive Lead**

Reference			
SA4.3	That the scale of change & integration agenda across the NHS could affect the sustainability of services & Trust financial position.	Risk to be merged with SA4.1.	John Lawlor
SA5.1	That we do not meet compliance & Quality Standards	Gaps in control/actions added.	Lisa Quinn
SA5.2	That we do not meet statutory and legal requirements in relation to Mental Health Legislation.	Gaps in control/actions added.	Rajesh Nadkarni
SA5.3	That we misreport compliance and quality standards through data quality errors.	Action amended	Lisa Quinn
SA5.7	That we do not have effective governance arrangements in place.	Gaps in control/actions added.	Lisa Quinn
SA5.8	Failure to develop NTW academy resulting in the lack of enhanced further nursing supply	Controls added, Gaps in control/actions added.	Gary O'Hare

1.3. Risks to be de-escalated.

Following review of the BAF/CRR with each of the lead Executive Directors/Directors there has been 4 risks de-escalated in this quarter.

Risk Reference	Risk description	Risk Appetite	Risk score	Executive Lead	Comment
SA1.1	That we do not implement service model changes as planned, failing to realise the benefits of improved quality and better outcomes.	Quality Effectiveness (6-10)	10	James Duncan	To be de-escalated to Chief Operating Officer to mitigate from an Operational approach.
SA2.1	That we do not sufficiently engage with GP's, Communities, Stakeholders and System Partners in supporting and enabling effective interventions.	Quality Effectiveness (6-10)	10	James Duncan	Following the clinical transition and move to devolved structures risk to be de-escalated to Chief Operating Officer for review and further mitigation operationally within locality groups.

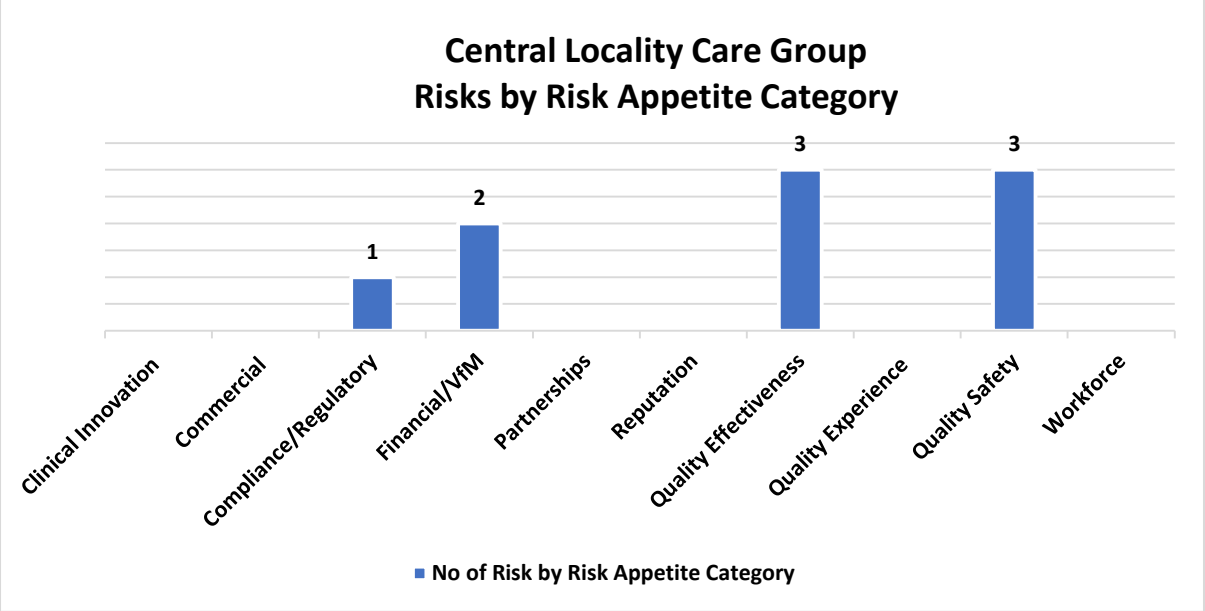
The following risks have been reviewed and a decision to merge with a current risk on the Board Assurance Framework/Corporate Risk Register has been made by the Executive Lead.

Current Risk ref:	Current Risk Description	New Risk ref:	New Risk Description
SA1.6	Lack of Ownership of PFI buildings. Restrictions in contract hinder ability to develop estate.	SA1.2	Restrictions on capital funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing the risk of harm to patients through continuing use of sub optimal environments
SA3.2	NTW being marginalised in STP leading to impact on integration agenda.	SA3.2	That we do no influence the development of new care models (ACO, MCP, ACS, STP) leading to increased fragmentation of MH service delivery.
SA4.3	That the scale of change and integration agenda across the NHS could affect the sustainability of services and the Trust's Financial Position.	SA4.1	That we have significant loss of income through competition, choice and national policy, including the possibility of losing large services and localities.

2.0. Clinical Locality Care Groups and Executive Corporate Trust Risk Registers.

The below charts show a summary of the number of risks by risk appetite category held by each Locality Care Group (Group Risk Register) and Executive Corporate risk registers. In the quarter the Clinical Care Groups have moved to a Locality Structure and so risks have been reviewed and transferred to the most appropriate locality risk register to be managed effectively. Therefore Central Locality Care Group now hold 9 Group risks, North Locality Care Group hold 14 Group Risks and South Locality Care Group hold 12 Group Risks. Safeguard Web Risk Management and Risk appetite has been fully implemented throughout the group risk registers/executive corporate risk registers and risk continue to be monitored at the CDT Risk Management Sub Group on a monthly basis.

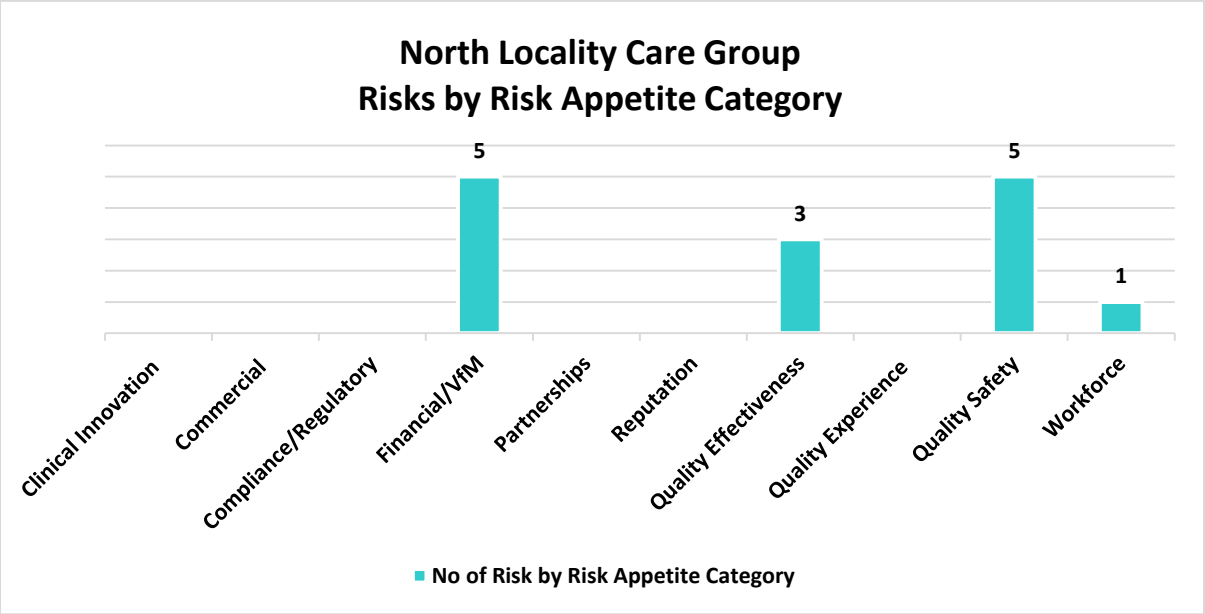
2.1 Clinical Groups



Central Locality Care Group as at December 2017 hold 9 risks, 1 risk lower than the risk appetite, 2 risks within the risk appetite and 6 risks which have exceeded the risk appetite. All risks are being managed within the Community Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1038.v7	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Tim Docking
1067.v5	Duplicate prescribing by NTW Prescribers and GP's resulting in patients receiving double dosing of medication.	Quality Safety (1-5)	8	4	2	Tim Docking

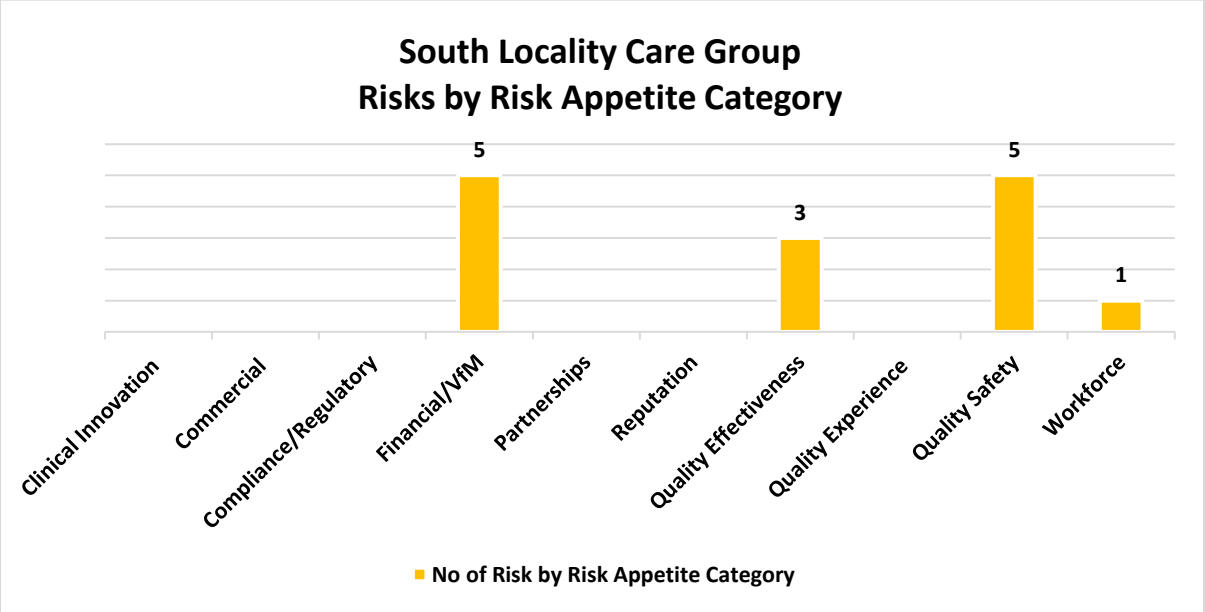
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1127.v2	Audit report NTW15/16 identified findings linked to the monitoring of clinical Audit Policy including the reporting mechanism for reports and monitoring of clinical audits.	Compliance/ Regulatory (6-10)	12	4	3	Tim Docking
1175.v2	Access and waiting times within community services, increased level of referrals being made, assessments are being completed but through flow of patients is not keeping pace with number of referrals so there are increasing waiting lists for treatment	Quality Effectiveness (6-10)	12	4	3	Tim Docking
1513.v2	Access and waiting times within ADHD/ASD service. Weekly reports indicate that there has been no significant improvement in flow and the waiting lists are not reducing. Discussion regarding capacity and demand with commissioners however no further investment has been made to date.	Quality Effectiveness (6-10)	15	3	5	Tim Docking
1545.v1	Potential ligature risk identified within central locality care group wards during CERA process 2017-2018.	Quality Safety (1-5)	20	5	4	Tim Docking



North Locality Care Group as at December 2017 hold 14 risks, 4 risk lower than the risk appetite, 3 risks within the risk appetite and 6 risks which have exceeded the risk appetite. All risks are being managed within the North Locality Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1176.v4	There are increasing difficulties recruiting and retaining clinical staff within Northumberland Locality.	Quality Effectiveness (6-10)	20	5	4	Russell Patton
1184.v6	If we were to fail to address CQC outcome shortfalls (Musts and Shoulds) in an effective timely manner this could be potentially damaging to our CQC outstanding status.	Quality Safety (1-5)	6	3	2	Russell Patton
1203.v3	Internal audit report has identified service level issues in the low use of identicom lone working devices.	Quality Safety (1-5)	15	5	3	Russell Patton
1287.v1	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Russell Patton

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1291.v1	Internal doors have been identified as a potential ligature risk following incidents across the Trust.	Quality Safety (1-5)	16	4	4	Russell Patton
1301.v1	Outcome of Transition Audit concludes that there is an overall level of non-compliance with 72 hour review, care coordination review and discharge planning.	Quality Safety (1-5)	15	5	3	Russell Patton

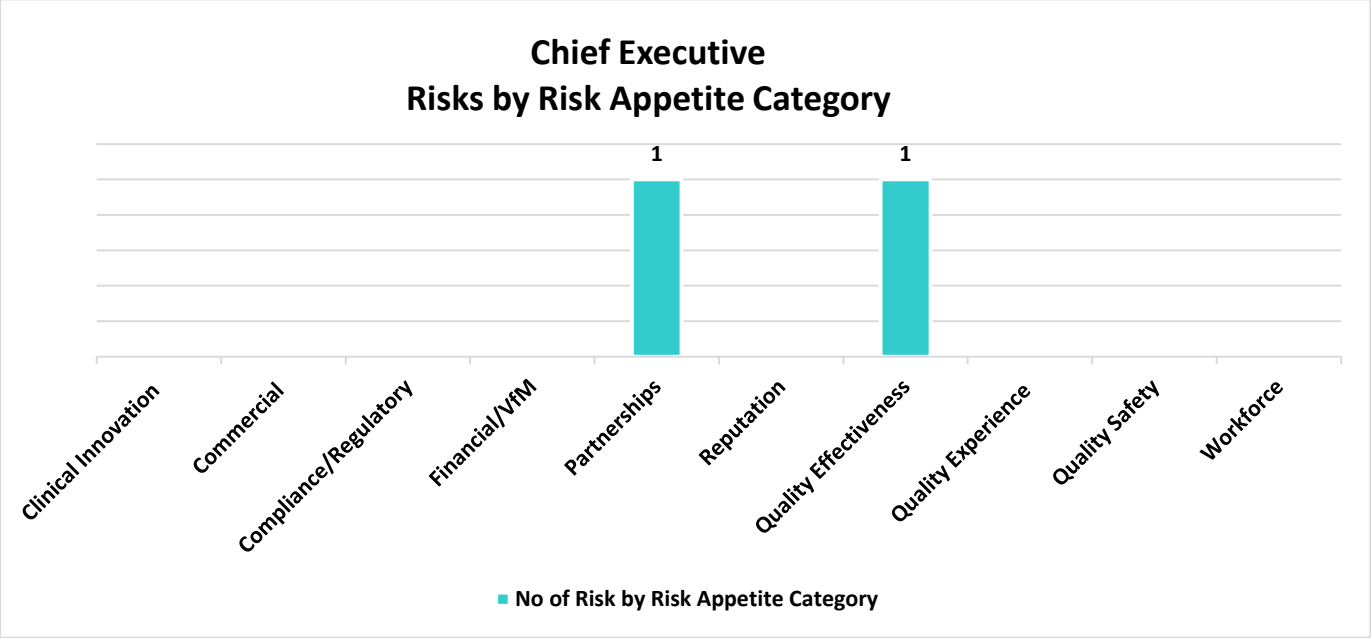


South Locality Care Group as at December 2017 hold 12 risks, 3 risk lower than the risk appetite, 4 risks within the risk appetite and 5 risks which have exceeded the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

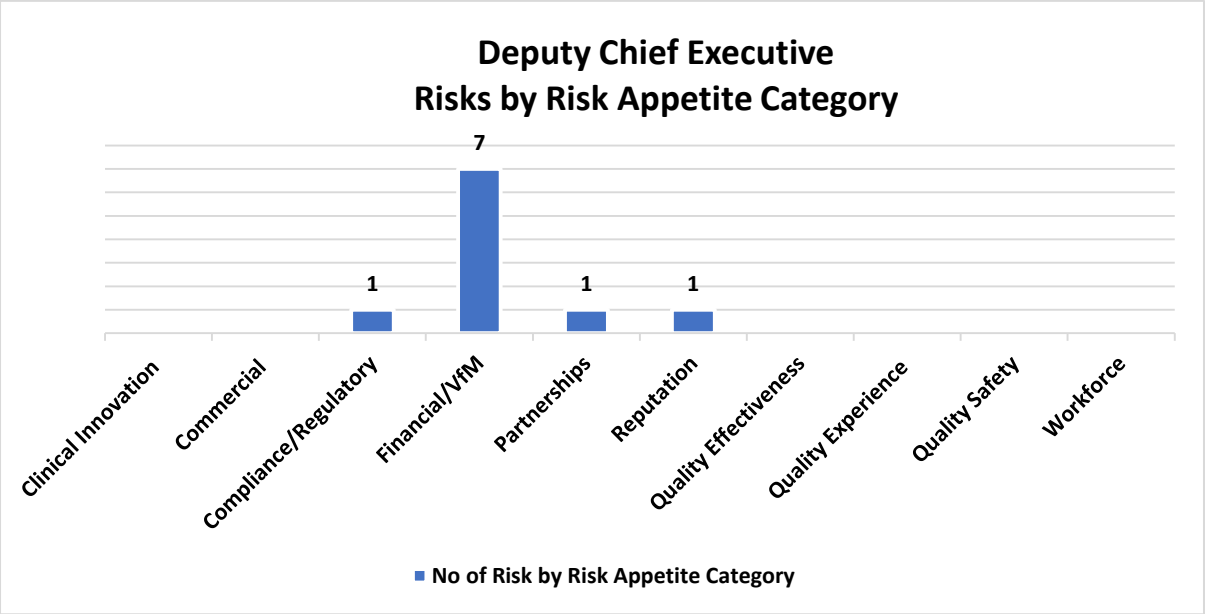
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1164.v3	Lack of local availability of section 12 doctors to undertake MHA assessments leading to delay in assessments being carried out.	Quality Effectiveness (6-10)	12	4	3	Sarah Rushbrooke
1288.v2	Medication pages on RiO are not being kept up to date as per NTW Policy.	Quality Safety (1-5)	16	4	4	Sarah Rushbrooke

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1294.v1	Increased levels of referrals. Assessments being completed but through flow of patients is not keeping pace with the numbers of referrals so there are increasing waiting lists for treatment which could result in a financial impact and significant effects on care.	Quality Effectiveness (6-10)	16	4	4	Sarah Rushbrooke
1300.v1	Outcome of transition audit concludes that there is an overall level of non-compliance in relation to 72 hour reviews, care coordination review and discharge planning meetings.	Quality Effectiveness (6-10)	15	5	3	Sarah Rushbrooke
1497/v1	Staffing pressures due to vacancies and difficulty recruiting and retaining medical staff within the south locality group.	Workforce (12-16)	20	5	4	Sarah Rushbrooke

2.2. Executive Corporate.

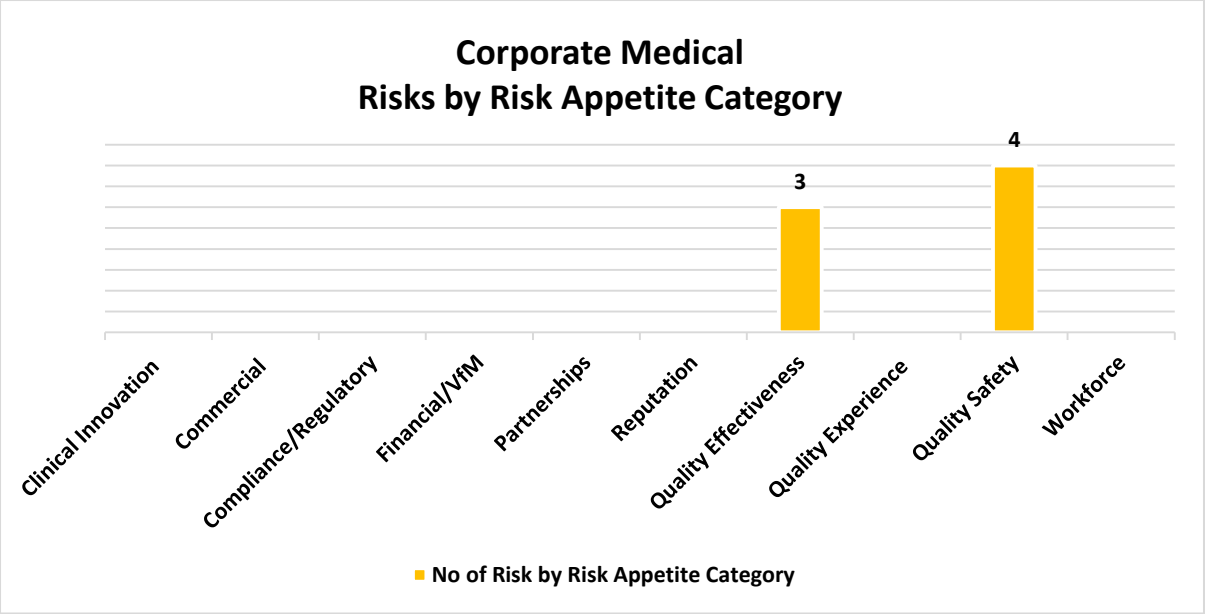


The Chief Executive as at December 2017 hold 2 risks, 1 risk lower than the risk appetite, and 1 risk within the risk appetite. No risks have exceeded a risk appetite. All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.



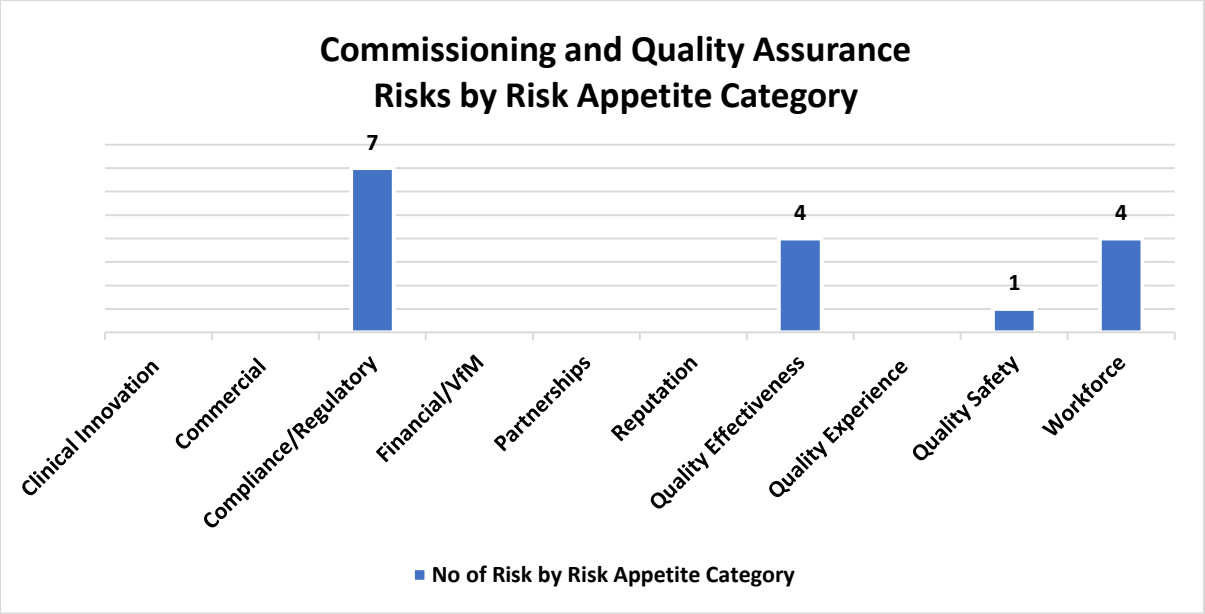
The Deputy Chief Executive as at December 2017 hold 10 risks, 1 risk lower than the risk appetite, and 6 risks within the risk appetite and 3 risks which have exceeded a risk appetite. All risks are being managed within the Chief Executive's Office with the exception of 1 risk **(no. 1299.v3)** which the Deputy Chief Executive has asked to be escalated to BAF/CRR. Risks which have exceeded a risk appetite and risk escalations are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1299.v3	That we do not manage our resources effectively through failing to deliver the required service change, productivity gains required and failing to meet the Trust's Control Total.	Finance/VfM (12-16)	20	5	4	James Duncan
1437.v1	That the Trust fails to achieve its control total of £7.1m	Finance/VfM (12-16)	20	5	4	David Rycroft
1440.v1	That the Trust fails to deliver the Financial Delivery Plan saving scheme.	Finance/VfM (12-16)	20	5	4	Chris Cressey



The Executive Medical Director as at December 2017 holds 7 risks, 3 risks within the risk appetite and 4 risks which have exceeded a risk appetite. All risks are being managed within the Medical Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

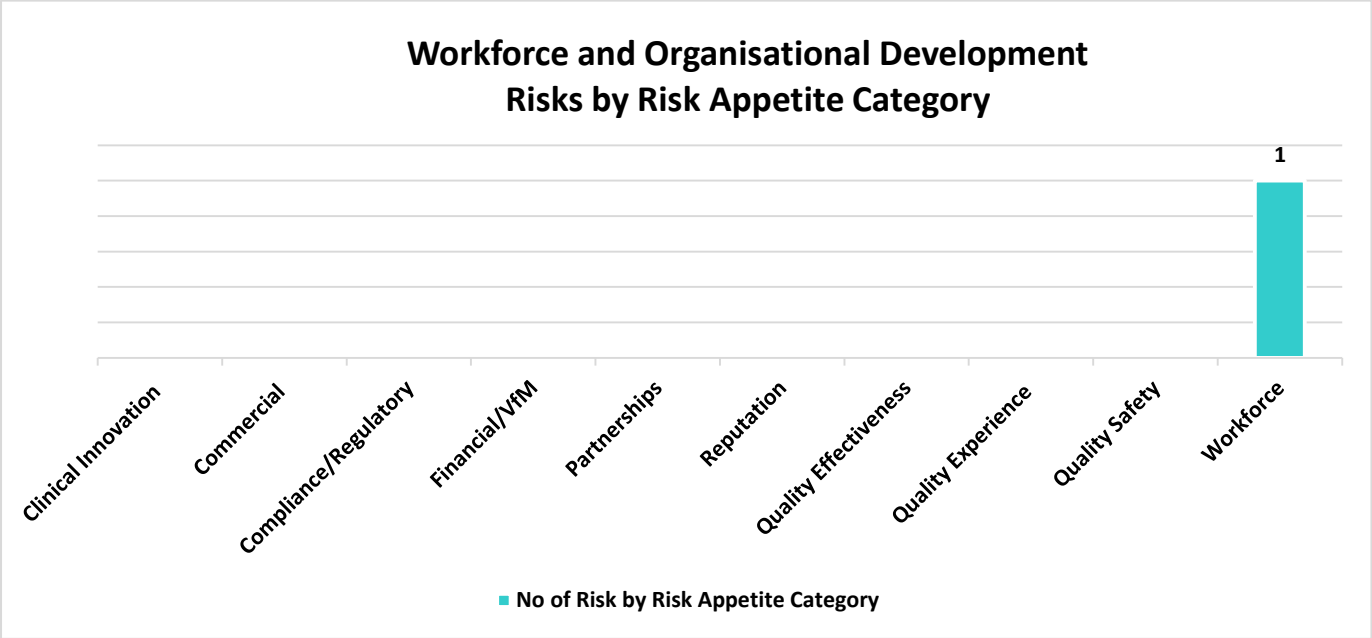
Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1057.11	Unable to provide equitable patient specific clinical pharmacy services to community teams due to limited resources and the prioritisation of inpatient services	Quality Safety (1-5)	12	4	3	Claire Thomas
1205.v1	Occasional delays seen by CQC in the allocation of SOADs impacting on patient treatment pathways.	Quality Safety (1-5)	6	3	2	Rajesh Nadkarni
1220.v8	Women of childbearing age are prescribed sodium valproate without appropriate awareness of risks involved.	Quality Safety (1-5)	10	5	2	Andrew Cairns
500.v10	Electronic prescribing – handwritten prescriptions increasing risk of prescribing and admin errors.	Quality Safety (1-5)	9	3	3	Ewan Maule



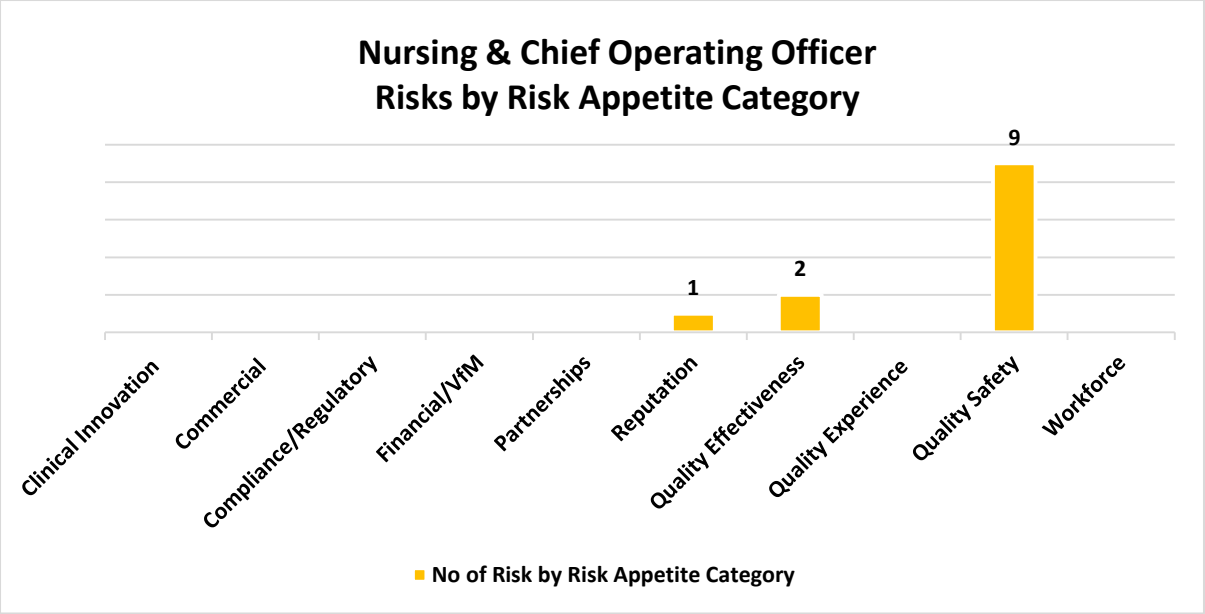
The Executive Director of Commissioning and Quality Assurance as at December 2017 holds 16 risks, 2 risks lower than the risk appetite, 7 risks within the risk appetite and 7 risks which have exceeded a risk appetite. All risks are being managed within Commissioning and Quality Assurance and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1215.v2	Failure to comply with section 7 of the data protection – there are barriers to prevention compliance with the data protection act within the trust.	Compliance/ regulatory (6-10)	12	4	3	Angela Fail
1049.v1	If substantive qualified nurses are required to set up temporary nurse user accounts then they may be able to potentially register a fictional temporary nurse user and gain access to controlled drugs.	Compliance/ Regulatory (6-10)	12	4	3	Gillian Sanderson
1172.v4	Increased risk of security threats coupled with increasing type and range of device access to the network linked to technology developments increasing attack vectors and increased sophistication of exploits.	Quality safety (1-5)	12	4	3	Jon Gair

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1251.v2	There is a potential risk to non-compliance to the implementation of the new GDPR May 2018.	Compliance/ Regulatory (6-10)	16	4	4	Angela Fail
538.v3	Information governance issues, particularly relating to manual HR records/high levels of filing which could result in information being misplaced or lost.	Compliance/regulatory (6-10)	16	4	4	Angela Fail
697.v1	Unencrypted data being sent to external webmail addresses and other networks from ntw.nhs.uk	Compliance/ Regulatory (6-10)	12	4	3	Darren McKenna
814.v2	Risk assessments for critical business systems have identified risks on ESR/Oracle/RiO/Network/ IPT/email relating to BCP with mitigating controls which have been reported to the SIRO.	Quality Effectiveness (6-10)	12	4	3	Lisa Quinn



The Executive Director of Workforce and Organisational Development as at December 2017 holds 1 risk which is within the risk appetite. No risks to escalate to the BAF/CRR have been received.



The Nursing & Chief Operating Officer as at December 2017 holds 11 risks, 1 risk lower than the risk appetite, 2 risks within the risk appetite and 8 risks which have exceeded a risk appetite. All risks are being managed within Nursing & Chief Operating Officer Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1087.v7	Changes to funding for forensic community personality disorder team have shown CMHTs to be receiving an increased number of referrals for forensic service users with antisocial PD, psychopathy and risk behaviours. There is a gap between the service provided by the PD Hub and patients being referred to CMHTs who do have the relevant training for patients who do not fit criteria for acceptance into the PD forensic team.	Quality Effectiveness (6-10)	20	5	4	Gary O'Hare
1212.v3	That we are organisationally non-compliant with NICE NG10 recommendations with no plans to change practice to achieve compliance relating to statement 1.4.3 and 1.4.4.	Quality Safety (1-5)	9	3	3	Gary O'Hare

Risk Reference	Risk Description	Risk Appetite	Risk Score	S	L	Owner
1252.v3	Trust Internet does not have a full and current list of all Trust Approved Policies. Due to development of the Trust Website this will take a period of time to update due to current capacity in the policy team.	Quality Safety (1-5)	6	3	2	Tony Gray
1265.v1	To comply with national guidance on learning from deaths the Trust will have a capacity issue to achieve a review of all appropriate deaths. The Trust has suitable resource to investigate all serious incidents and any deaths subject to concise investigation as agreed with directors.	Quality Safety (1-5)	6	3	2	Claire Taylor
302.v7	The Trust do not have the capacity to interpret ECG Readings for patients being screened who may be prescribed antipsychotics	Quality Safety (1-5)	12	4	3	Gary O'Hare
478.v4	Unable to recruit required number of medical staff to support clinical areas resulting in inability to provide safe, effective and high class services	Quality Effectiveness (6-10)	16	4	4	Gary O'Hare
576.v5	The provision of safe and effective care within inpatient wards on non ntw sites is compromised due to the location of the facilities resulting in little direct control over environmental issues e.g. clinical layout, two storey building, appropriate/timely maintenance.	Quality Safety (1-5)	16	4	4	Gary O'Hare
628.v5	Risk of fire resulting from service users smoking in contravention of the Trust wide Smoke Free Policy resulting in damage to building and/or loss or life.	Quality Safety (1-5)	10	5	2	Gary O'Hare

3. Emerging Risks.

Emerging Risks are reviewed at the CDT Risk Sub Committee monthly. Any emerging risks identified by the committee will be detailed below.

4. Recommendation

The Board of Directors are asked to:

- Note the changes and approve the BAF/CRR.
- Note the risks which have exceeded a risk appetite.
- Note any risk escalations.
- Note the summary of risks in the Locality Care Groups/corporate Directorate risk registers.
- Provide any comments of feedback.

Natalie Yeowart
Risk Management Lead
January 2018

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

2017-18

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not implement service model changes as planned, failing to realise the benefits of improved quality and better outcomes.	Risk on identification (Feb 2012):	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	5	**2**	10	**Low**
	Risk Appetite:	**Quality Effectiveness**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(actions to take to achieve target)**
1. Integrated Governance Framework. 2.Business Case and Tender Process (PGN). 3. Commissioner involvement and scrutiny. 4. Decision Making Framework	1.Independent review of governance against Well-Led Framework January 2016-Strategy 1. Single Oversight Framework Governance rating green. 2. NTW1617 36 Responding to Tenders - Substantial Assurance. 3. Feedback at CDT Monthly. 4. NTW1617 20 Quality Impact of FDP - Substantial Assurance	1. Post Project Evaluation - Nov 2017 2. Review of Improving Community Pathways. 3. Review of effectiveness of service user/carer engagement. 5. Newcastle/Gateshead Deciding Together Update December 2017.

Ref: SA1.1

Review Comments: Target score achieved. To de-escalate to Chief Operating Officer to mitigate from a operational approach.

Executive Lead: Deputy Chief Executive	**Board Committee: RBAC**	**Updated/Review Date: December 17**

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Restrictions on capital funding nationally and lack of flexibility on PFI leading to a failure to meet our aim to achieve first class environments to support care and increasing the risk of harm to patients through continuing use of sub-optimal sub-optimal environments.	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Finance/VfM**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (actions to achieve target risk)
1. CEDAR Programme Board Established with key Partners.	1. Minutes of CEDAR Programme Board 1. Feedback/update via Sub Committees/board	1. National Capital Allocation process unclear Quarterly updates via Sub Committees/board. 2. Identification of opportunites for funding 3. Link NTW capital proposals into developing STP plan.

Ref: SA1.2

Review Comments: Risk now includes SA1.6. Risk revised due to further capital/PFI changes. Controls removed and new added. Gaps in control removed and new added.

Executive Lead: Deputy Chief Executive	**Board Sub Committee: RBAC**	**Updated/Review Date: December 2017**

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services.	Risk on Identification	4	**3**	12	**Moderate**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Quality Effectiveness:**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1.Integrated Governance Framework. 2.Agreed contracts in place and framework. for managing change. 3.Locality Partnerships.	1. Independent review of governance-Process and structures-includes engagement with stakeholders-Amber/Green rating assessment. 2.Contract monitoring and contract change reporting process to CDT and RBAC. 3. Updates from Locality Partnership meetings	1. Well Led Review Action Plan to be agreed with Board January 2018 2. No contract in place with Northumberland Agreed but not signed - 2018. (amended from Nov 2017)

Ref: SA1.3

Review Comments: timescales amended, residual risk score increased from 4x2(8) to 4x3(12)

Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: RBAC**	**Updated/Review Date: December 2017**

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their journey to wellbeing.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are subsequently not sufficiently responsive to demands.	Risk on identification (Feb 2012):	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	4	**2**	8	**Low**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Quality Safety:**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (actions to take to achieve target)
1.Integrated Grovernance Framework. 2.Performance review monitoring and reporting incl compliance with standards, indicators,CQINN. 3.Operational and Clinical Policies and Procedures. 4. Annual Quality Account. 5. CQC Compliance Group.	1.Independent review of governance against Well-Led Framework January 2016-Clearly defined processes for managing performance Amber/Green rating. 1/2/4.External Audit of Quality Account 1.Operational Plan 2016/17 reviewed by NHSI. 2.Reports to CDTQ,Q&P and QRG's. 5. CQC review rated outstanding. 2. NTW16/17 53 Penetration Test Trust Network Reasonable assurance.	2. Delivery of Operational Plan 17/18 3. Delivery of 5 Year Trust Strategy 2017-2022 and supporting strategies. Milestones tbc 4. Evidence benefit realisation from service change Trustwide. April 2018

Ref: SA1.4

Review Comments: No change.

Executive Lead: Executive Director of Nursing	**Board Sub-Committee: Q&P**	**Reviewed: December 2017**

Northumberland, Tyne and Wear NHS Foundation Trust

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Lack of ownership of PFI buildings. Restrictions in contract hinder ability to develop estate.	Risk on Identification	3	**4**	12	**Moderate**
	Residual Risk (with current controls in place):	3	**4**	12	**Moderate**
	Target Risk (after improved controls):	3	**1**	3	**Very Low**
	Risk Appetite:	**Finance/VfM**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(actions to achieve target risk)**
1.PFI Contract documentation. 2.Local Procedures re carrying out work on PFI developments. 3.Monitoring of PFI Contracts.	1.IA 1516NTW/32 PFI Contract Monitoring. Significant assurance with issues of note. 2. DTZ (Chartered Surveyors) continual review of estate. 3. Outline Business Case. 3. NTW1718 21 PFI Contract Monitoring	1. Progress discussions regarding purchase of PFI developments Quarterly updates. 2. Review Lack of Capital Control.

Ref: SA1.6

Review Comments: RISK MERGED WITH SA1.2 - RISK TO BE REMOVED.

Executive Lead: Deputy Chief Executive	**Board Sub Committee: RBAC**	**Updated/Review Date: December 2017**

Strategic Ambition: 1
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

Corporate Risk:	Risk Rating:	Impact	Likelihood	Score	Rating
That staff do not follow Information Governance, Caldicott and Informatics Policies and procedures.	Risk on Identification	5	**2**	10	**Low**
	Residual Risk (with current controls in place):	4	**2**	8	**Low**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Compliance & Regulatory:**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Actions to achieve target risk)
1.Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Caldicott and Health Information Group. 4.Information Governance Toolkit. 5. Monitoring of Information Governance training levels and action plans.	1.External Audit of Annual Governance Statement. 1/3/4.Reports to Sub Committees of the Board and Action Plans. 1/2/4.Information Risk Review by ICO (May 2016) and Action Plan. 4 NTW1617 46 IGT - substantial assurance 2. NTW1617 Information sharing with commissioners - substantial assurance 5. Accountability Framework Quarterly Document.	1. Improve Mandatory Training for Staff by achieving target of 95% (currently 90.1%) by Feb 2018

Ref: SA1.7

Review Comments: Assurances added.		
Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: December 2017**

Strategic Ambition: 6
The Trust will be regarded a "great place to work"

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Failure to participate and influence STP workforce developments may reduce our control over future regional workforce changes.	Risk on identification (April 2017):	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	4	**4**	16	**Moderate**
	Target Risk (after improved controls):	3	**3**	9	**Low**
	Risk Appetite:	**Workforce**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (Actions to achieve target risk)
1. Regional Workforce Action group 2. Local Workforce Action Board 3. Social Partnership Forum - WF Director Chair. 4. Deputy CEO leading STP workstream	1. Minutes of Regional Workforce Action Group 2. Minutes of Local Workforce Action Board 3. Minutes of Social Partnership Forum 4. Feedback/updates from STP workstreams via CDT/Q&P/Board	1. Workstreams at early stages of development. 2. Await further information on intentions and agreement to develop a regional WF strategy and associated infrastructure. Dec 17

Ref: SA1.8

Review Comments: Minor language change to control no 3 otherwise remains the same.

Executive Lead: Director of Workforce & OD	**Board Sub Committee: Q&P**	**Last Updated/Reviewed: December 2017**

Strategic Ambition: 2
With People, Communities and Partners, together we will promote prevention, early intervention and resilience.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not sufficiently engage with GP's, communities, stakeholders and system partners in supporting, enabling effective interventions.	Risk on identification (May 2017):	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Quality Effectiveness**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (Actions to achieve target risk)
1. Engagement in developing community models of care with locality partners 2. Central role on Mental Health STP 3. Engagement in prevention early intervention 4. Engagement and support of recovery colleges 5. Regional healthcare strategy.	1. GP Survey	1. Development of locality board for GP for GP engagement. April 2018 2. Development of evidence base for recovery colleges - content development - April 2018 3. Development of implemented action plan for MH aspects of STP pathway - April 2018

Ref: SA2.1

Review Comments: Following clinical transition risk to be de-escalated to Chief Operating Officer for review and further mitigating operationally within locality groups.

Executive Lead: Deputy Chief Executive	**Board Sub Committee: Q&P**	**Last Updated/Reviewed: December 2017**

Strategic Ambition: 3
Working with partners there will be "no health without mental health" and services will be "joined up"

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not further develop integrated information systems across partner organisations.	Risk on Identification	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	3	**3**	9	**Low**
	Target Risk (after improved controls):	3	**2**	6	**Low**
	Risk Appetite:	**Safety**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1.Integrated Governance Framework. 2.IMT Strategy. 3.Trust Information Sharing Policy. 4.Local partnership agreements and contracts/ sub contracts incl information sharing across organisational boundaries. 5.Caldicott Health Information Group. 6. Locality Partnerships.	1.External Audit of Annual Governance Statement. 1/2/3.Informatics Highlight Report to FIBD. 4/6.Locality and Partnership updates to CDT. 5.Caldicott Health Information Group report. to Q and P.	1. Audit of information sharing agreements 2. Completion of MIG - April 2018 3. Completion of roll out of WIFI/Internet for partners - April 2018

Ref: SA3.1

Gap in control/action no.2 timescales updated.		
Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: December 2017**

Strategic Ambition: 3
Working with partners there will be "no health without mental health" and services will be "joined up"

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not influence the development of new care delivery models (ACO, MCP, ACS, STP) leading to increasing fragmentation of MH service delivery.	Risk on identification (May 2017):	5	**4**	20	**High**
	Residual Risk (with current controls in place):	4	**4**	16	**Moderate**
	Target Risk (after improved controls):	3	**3**	9	**Low**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Executive and Group leadership embedded within each CCG/LA area to ensure that the specilaist MH and disabilities services are safeguarded and parity is a key part of integration plans. 2. Leadership of the STP MH workstream.	1. Successfully influenced service models and across a number of localities. 2. Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices. 2. Regular update/monitoring of STP via Exec/CDT/Board.	1. Impact of new ACS, ACO & MCP proposals still at an early stage with a number of the new care models focused around integrating acute, community and social care 2. Changes to STP implementation plans with changes being considered to move to a single NE&Cumbria ACS which may effect priorty given to our service users being diluted. 3. Tender process for MCP

Ref: SA3.2

Review Comments: Risk reviewed by deputy CEO- action added.

Executive Lead: Chief Executive	**Board Sub Committee: Board**	**Last Updated/Reviewed: December 2017**

NHS
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Strategic Ambition: 6
The Trust will be regarded as "a great place to work"

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Failure to participate and influence regional developments relating to Carter and Back Office Functions resulting in imposed changes to corporate functions and arising recruitment and retention issues.	Risk on identification (May 2017):	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	4	**4**	16	**Moderate**
	Target Risk (after improved controls):	**3**	**3**	9	**Low**
	Risk Appetite:	**Workforce:**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence** (how do we know we are making an impact)	**Gaps in Controls** (Actions to achieve target risk)
1. Monitored at DOF Network and HRD Network 2. WFD Member of NHSI expert panel 3. WFD member of NHS employers streamlining national strategy forum.	1. Minutes of Network meetings 2. Feedback/updates via CDT/Q&P/Board 3. Feedback/updates via CDT/Q&P/Board	1. Await second round of more accurate benchmarking data to be collated and released Jan 18.

Ref: SA3.3

Review Comments: Risk reviewed - no change in quarter.

Executive Lead: Director of Workforce & OD	**Board Sub Committee: Q&P**	**Last Updated/Reviewed: December 2017**

Strategic Ambition: 3
Working with partners there will be "no health without mental health" and services will be "joined up"

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
NTW being marginalised in STP leading to impact on integration agenda.	Risk on identification (May 2017):	**5**	**3**	**15**	**Moderate**
	Residual Risk (with current controls in place):	**5**	**2**	**10**	**Low**
	Target Risk (after improved controls):	**4**	**1**	**4**	**Very Low**
	Risk Appetite:	**Quality Effectiveness**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Active engagement in Sunderland MCP, member of Partnership Board 2. Membership of Newcastle Gateshead AOs Meeting 3.Membership of Gateshead Accountable Care Partnership Board 4. Member of Newcastle Task Force 5. Strategic Partner of Northumberland ACO 6. Joint sponsors of Mental Health STP 7. Active engagement in CNE Leadership Forum	1,2,3,4,5,7 Regular updates through CDT.	1. Locality leadership model to be embedded 2. Formal MOU /partnership agreements

Ref: SA3.4

Review Comments: Risk reviewed - decision to merge risk with SA3.2 then close.

Executive Lead: Deputy Chief Executive	**Board Sub Committee: Board**	**Last Updated/Reviewed: December 2017**

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Strategic Ambition 4
The Trusts Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we have significant loss of income through competition, choice and national policy,including the possibility of losing large services & localities.	Risk on identification May 2009):	4	**4**	16	**Moderate**
	Residual Risk (with current controls in place):	5	**4**	20	**High**
	Target Risk (after improved controls):	5	**2**	10	**Low**
	Risk Appetite:	**Finance/VfM**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(actions to take to achieve target)**
1.Integrated Governance Framework. 2.Financial Strategy. 3.Agreed contracts in place and framework for managing change. 4. Locality partnerships. 5. New Models of Care for CAMHS Tier 4 and forensic services. 6. Business Case and Tender Process (PGN). 7. Horizon Scanning. 8. Commissioning and Quality Assurance Proceedures.	1/2. Annual Governance Statement and Annual Accounts subject to External Audit. 2.Operational Plan 2017/18 3. NTW1617 27 Agreements -substantial Assurance with no issues of note. 4. Quarterly partnership Meeting minutes 6. NTW1617 36 Responding to Tenders - Substantial Assurance with minor remedial Action Required. 8. Compliance with comissioning and contract requirements.	1. Confirm Trust Approach to Marketing Apr 18 2. Capacity to manage multiple tenders proposal to be developed. Apr 18 3. MCP approach tender - Apr 18 4. Rebasing of Budget - Mar 18 5. Lack of certainty around commissioning for regional forensic - Apr 18 6. Provision plan - new care models -Apr 18

Ref: SA4.1

Review Comments: Residual risk score increased from 5x3 to 5x4. Risk has now exceeded risk appetite. Further gaps in control/actions added.

Executive Lead: Deputy Chief Executive	**Board Sub-Committee: RBAC**	**Updated/Review Date: December 2017**

Strategic Ambition: 4
The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That the scale of change & integration agenda across the NHS could affect the sustainability of services & Trust financial position.	Risk on identification (October 2015):	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**3**	15	**Moderate**
	Target Risk (after improved controls):	4	**3**	12	**Moderate**
	Risk Appetite:	**Quality Effectiveness**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (actions to achieve target risk)**
1.Integrated Governance Framework. 2.Stakeholder and partner locality Group Leads, reporting processes and CBU locality model. 3.Horizon scanning and intelligence. 4.Financial Strategy. 5. Oversight Model.	1/5 Green Governance rating assessment. 1/2/3.Reports to Board on STP and associated service and integration agenda & consideration of locality working through BDG & Execs. 4. Operational Plan 2017/19 reviewed by NHSI.	1. Contribution to and approval of Local Health System Sustainability and Transformation Plans. 2. 5 year Trust Strategy - development of milestones. 3. CCG/LA comms plans and new models of care. (e.g ACO & MSPs) 4. NHS England procument plan for Eating disorder, Gender and Secure Services. 5. Delivery of New Models of Care.

Ref: SA4.3

Review Comments: Reviewed by Deputy CEO - risk to be merged with SA4.1 then close.

Executive Lead: Chief Executive	**Board Sub-Committee: Board**	**Updated/Review Date: December 2017**

Strategic Ambition: 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not meet compliance & Quality Standards	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Compliance/Regulatory:**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Compliance with NICE Guidance. 4.CQC Compliance Group-review of compliance and Action Plans. 5.Performance Review/Integrated Commissioning and Assurance reports. and Action Plans. 6. Accountability Framework. 7. Regulatory framework of CQC and NHSI.	1.Independent review of governance -Process and structures-clearly defined processes for escalating and resolving issues and managing performance-Amber/Green rating assessment. 1/3/4/5.Reports/Updates to Board sub Committees. 2/3/4/5.See list of significant assurance Audits including BAF Clinical Audits 2015/16 in audit assurances tab. 2/3/4.CQC MHA compliance visits and completed action plans. 7. NTW1718 09 CQC Process Substantial assurance.	1. CQC Comprehensive Inspection action plans all complete with exception of environmental changes to Alnwood. 2. Well led review action plan to be agreed by board. Oct 17 3. CQC Steering Group key areas of enhanced focus - March 2018.

Ref: SA5.1		
Review Comments: Gap in control/Action added.		
Executive Lead: Executive Director Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: December 2017**

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Strategic Ambition 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not meet significant statutory and legal requirements in relation to Mental Health Legislation	Risk on Identification	4	**3**	12	**Moderate**
	Residual Risk (with current controls in place):	4	**3**	12	**Moderate**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Compliance/Regulatory:**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1.Integrated Governance Framework. 2.Trust Policies and Procedures relating to relevant Acts and practice. 3.Decision Making Framework. 4.Review of CQC MHA Reports and monitoring of Action plans. 5.Performance Review/Integrated Performance Report and Action Plans. 6. Mental Health Legislation Committee.	1.Independent review of governance -Process and structures-clearly defined processes for escalating and resolving issues and managing performance-Amber/Green rating assessment. 1/4/5.Reports to Board and sub Committees 2. Compliance with policy/training requirement 2. NTW1617 33 MHA Section 17 Good level of assurance 2. NTW1617 34 MHA Section 136 good level of assurance. NTW1718 09 CQC Process Substantial Assurance.	1. IA 1415/NTW/30: MHA Patients Rights Complete management actions identified in limited assurance audit & re-audit. 2. Delivery of robust process for 135/136 legislation with external stakeholders. 3. 135/136 legislation action plan.

Ref: SA5.2

Review Comments: Gaps in control/Actions added.

Executive Lead: Executive Medical Director	**Board Sub Committee: MHL Group**	**Updated/Review Date: December 2017**

Strategic Ambition: 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	Risk Rating:	Impact	Likelihood	Score	Rating
That we misreport compliance and quality standards through data quality errors. (Risk Identified Nov 2015)	Risk on Identification (Nov 2015)	4	**2**	8	**Low**
	Residual Risk (with current controls in place):	4	**2**	8	**Low**
	Target Risk (after improved controls):	4	**1**	4	**Very Low**
	Risk Appetite:	**Compliance & Regulatory:**			**Within**

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Actions to achieve target risk)
1.Integrated Governance Framework. 2.Data Quality Policy. 3.Data Quality Improvement Plan. 4. Internal Data Quality Proceedures.	1.Independent review of governance -Is the Board assured of the robustness of information- Amber/Green rating assessment 2.Rolling programme of Internal Audits regarding tests of performance indicators, information governance returns and contracting indicators-Significant Assurance. 2. Data Quality Kite Marks introduced to board performance reporting.	1. Well Led Review Action Plan to be agreed by board Oct 2017 2. Improve data quality maturity index to 95% (currently 91.7%) by September 2018.

Ref: SA5.3		
Review Comments: Action amended		
Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: Q&P**	**Updated/Review Date: December 2017**

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Strategic Ambition: 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	4	**2**	8	**Low**
	Risk Appetite:	**Quality Safety:**			**Exceeded**

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (Further actions to achieve target risk 2016/17)**
1.Integrated Governance Framework. 2.Trust Policies and Procedures. 3.Reporting and monitoring of complaints, litigation,incidents etc. 4.National Reports on Quality and Safety. 5.Health and Safety Inspections. 6.Trust Programme of Service and PLACE visits. 7.CQC Compliance Group. 8.Business Continuity Plans. 9.Quality Goals and Accounts.	1. Annual review of Governance Framework. 2. Policy Monitoring Framework including Auditable standards, KPI and Annual review. 3.Safety Report to Board Sub Committee and Board. 3/4/7/9.Performance reports to Q and P 5/6/7.Health and Safety,PLACE,service visit and CQC Action Plans. 2. NTW1617 32 Risk Management - Substantial Assurance with remedial actions to take 9.External Audit of Quality Account. 7. CQC Outstanding Review Rating.	1. IA NTW/1516/20: Medical Devices Complete management actions identified in limited assurance audit & re-audit. Due 18/19 2. Outcome and completion of Deciding Together. April 2018

Ref: SA5.5

Review Comments: No change.

Executive Lead: Executive Director of Nursing	**Board Sub Committee: Q&P**	**Updated/Review Date: December 2017**

NHS
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Strategic Ambition: 5
The Trust will be a centre of excellence for Mental Health and Disability.

Corporate Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
That we do not have effective governance arrangements in place.	Risk on Identification	5	**3**	15	**Moderate**
	Residual Risk (with current controls in place):	5	**2**	10	**Low**
	Target Risk (after improved controls):	5	**1**	5	**Very Low**
	Risk Appetite:	**Compliance & Regulatory:**			**Within**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1.Independent review of governance-Well Led Framework-Report Jan 2016. 2.Decision Making Framework. 3.Board Assurance Frramework. 4. CQC Comprehensive Inspecition 2016	1.Independent review of governance-Well Led Framework Action Plan. 2/3.External Audit of Annual Governance Statement. 2/3.Annual Review of Terms of Reference and effectiveness of key Committees. 4. CQC Outstanding rating public report.	1. Well Led Review Action Plan to be signed off by board - January 2018 2. External review - September 2018 3. CQC Well Led Inspection - 2018

Ref: SA5.7

Review Comments: Gaps in control/Actions added.

Executive Lead: Executive Director of Commissioning & Quality Assurance	**Board Sub Committee: Board**	**Updated/Review Date: December 2017**

Strategic Ambition: 5 The Trust will be a centre of excellence for Mental Health and Disability.

Principal Risk:	**Risk Rating:**	**Impact**	**Likelihood**	**Score**	**Rating**
Failure to develop NTW Academy resulting in the lack of enhanced future nursing supply.	Risk on identification (May 2017):	**4**	**5**	**20**	**High**
	Residual Risk (with current controls in place):	**4**	**5**	**20**	**High**
	Target Risk (after improved controls):	**4**	**3**	**12**	**Moderate**
	Risk Appetite:	**Workforce**			**Exceeded**

Controls & Mitigation **(what are we currently doing about the risk)**	**Assurances/ Evidence** **(how do we know we are making an impact)**	**Gaps in Controls** **(Actions to achieve target risk)**
1. Proposal to BDG July 2017 2. Board Development session Oct 2017 3. Academy Board Meeting 4. Council of Governors session	1. Minutes of BDG 2. Development session papers. 3. Minutes of Academy Board. 4. Minutes of Cog.	1. Further work needed on infrastructure 2. Approval by Board January 2018 3. Further detailed financial projections for Board.

Ref: SA5.8
Review Comments: Controls added, further actions added. NTW Academy supported by board but request for further detailed financial projections before approval.

Executive Lead: Director of Nursing	**Board Sub Committee: Q&P**	**Last Updated/Reviewed: December 2017**

Internal Audit Plan 2017/20			
Review Area	**2017/18**	**2018/19**	**2019/20**
Assurance Framework	•	•	•
Decision Making Framework	•		
Governance Structure		•	
Complaints and Claims Management – Handling/learning Lessons		•	
Openness and Honesty/Duty of Candour	•		•
Research and Development, including NIHR CRN Funding			•
Business Continuity Planning	•		
Integrated Emergency Management	•		
Third Party Assurance	•	•	•
Conflicts of Interest	•		
Risk Management (rolling programme)	•	•	•
Information Sharing		•	
IM&T Governance		•	
IM&T Strategy		•	
IM&T Risk Management			•
Cyber Security; Server Security & Administration	•	•	•
Cyber Security; Patch Management	•	•	•
Cyber Security; Backup and Recovery	•	•	•
Cyber Security; Malware and Antivirus Procedures	•	•	•
Cyber Security; Core network / LAN / Storage (SAN)		•	
Cyber Security; Active Directory and User Management			•
Cyber Security; Perimeter Security – Firewalls, External Links		•	
Cyber Security; Wireless Network	•		
Cyber Security; Cloud Services Provision (Office 365)	•		
Cyber Security; Data Centres - Physical and Environmental Controls	•		
Cyber Security; Network Infrastructure – Device Management			
Cyber Security; Server Virtualisation			
Cyber Security; Telephony/VoIP (Cisco IPT)	•		
Cyber Security; Web Filtering and Monitoring (IT Security)			•
Business Continuity/IT Disaster Recovery	•		

Review Area	2017/18	2018/19	2019/20
Desktop Management		•	
Mobile Computing/Security			•
Clinical and Operational System Reviews: RiO	•		
Clinical and Operational System Reviews:ePrescribing	•	•	
Clinical and Operational System Reviews: Ascribe Pharmacy			•
Clinical and Operational System Reviews: Omnicell			•
Clinical and Operational System Reviews: Backtraq			•
Clinical and Operational System Reviews: TAeR		•	
Clinical and Operational System Reviews: Digital Dictation		•	
Clinical and Operational System Reviews: IAPTus		•	
Clinical and Operational System Reviews: Safeguard			•
IT Service Management	•		
Software License Management		•	
Systems Development	•		
Financial Delivery Plan		•	
Pay Expenditure	•	•	•
Salary Overpayments		•	
Procurement	•	•	•
Financial Reporting & Budgetary Control	•	•	•
Financial Accounting/General Ledger	•	•	•
Accounts Payable	•	•	•
Accounts Receivable	•	•	•
Bank and Treasury Management	•	•	•
Stores and Stock		•	
Reference Costs	•		•
Cashiers (Rotational Coverage)		•	
Central Patients		•	
Monies and Belongings			
Non Pay PAYE		•	
Specific Service Audits	None Identified	•	•
Losses and Special Payments			•

Review Area	2017/18	2018/19	2019/20
Charitable Funds		•	
CQC Process	•		•
Sustainable Development / CRC Energy Efficiency Scheme			•
Information Governance Toolkit	•	•	•
NHS Premises Assurance Model		•	
NHS Improvement Single Oversight Framework		•	
Data Quality Improvement Plan/Data Quality Audit	•		•
NICE			•
Patient Experience (rolling programme)	•	•	•
Performance Management and Reporting (rolling programme)	•	•	•
Security Management (rolling programme)	•	•	•
Waste Management		•	
Transport	•		•
Fire Safety	•		•
Business Cases	•		
Organisational Culture (rolling programme)	•	•	•
Tendering for Clinical Services			•
Joint Working Arrangements (Sub Contracts)		•	
PFI Contract Monitoring	•		
Patient Care and Non Patient Care Activities Income	•	•	•
Asset Management	•		
Capital Planning & Monitoring	•		
Capital Procurement		•	
Delivery of Maintenance, Repairs & Improvements	•		
Recruitment & Selection (incl. pre-employment & rolling DBS checks)		•	
Time, Attendance and e-Rostering (TAeR) (rolling programme)	•	•	•
Medical Revalidation		•	
Professional Registrations		•	
Staff Appraisal		•	

Review Area	2017/18	2018/19	2019/20
Skills and Training (rolling programme)	•		•
Delivery of Occupational Health Service against Contract		•	
Monitoring of Absences	•		
Consultant Job Planning		•	
Equality and Diversity			•
Clinical Audit	•		•
Mortality Reporting		•	
Records Management	•		•
National Alert Systems	•		•
Safeguarding Arrangements	•		•
Infection Control	•		•
Medical Devices Management	•		•
Pharmacy Processes			•
Mental Health Act (Rolling Programme)	•	•	•
Health & Safety (Rolling Programme)	•	•	•
Follow up	•	•	•
Contingency	•	•	•
Strategic & Operational Planning	•	•	•
Annual Report	•	•	•
Audit Management	•	•	•

Clinical Audit Plan 2017/18

	Audit Topic	Board Assurance 3 Year Plan					
		17-18				18-19	19-20
		Q1	Q2	Q3	Q4		
1	Board Assurance Audits						
1.1	Clinical Supervision			●			
1.2	Nutrition			●		●	●
1.3	Medicines Management: Prescribing	●				●	●
1.4	MMRA Safe and secure handling				●		
1.5	Seclusion 16-17		●			●	●
1.6	Care Coordination Audit – Specialist Care		●			●	●
1.7	Care Coordination Audit – Inpatient Care Group			●		●	●
1.8	Care Coordination Audit – Community Services Group				●	●	●
1.9	Restraint				●		
1.1	Clustering					●	
1.11	High-dose Anti-psychotic Prescribing			●			
2.1	POMH-UK Topic 17a Use of Depot	●	●	●			
2.3	Neuro-Rehabilitation			●		●	●
2.4	National Audit of Anxiety and Depression						
2.5	National Audit of Psychosis						
3.1	Prescribing Valproate			●			
3.2	Audit of MDT Formulation in Stepped Care Units			●			
3.3	Audit of Local Level Clinical Audits			●			
4.1	High-dose Anti-psychotic Prescribing in Community Services			●			
4.2	6-monthly reviews of Depot Medication			●			
4.3	Explanation of Rights given to CTO within the 7 day follow-up process			●			
4.4	Unallocated case reviews and their allocation			●			
4.5	Clozapine Monitoring			●			
4.6	Timeliness of discharge summaries			●			
4.7	NICE CG192: Physical Health Monitoring in Pregnancy			●			
4.8	Observation and Engagement			●			
4.9	NICE NG72: Attention deficit hyperactivity Adult ADHD			●			

Final Audits received

Audit Ref	Audit Name	Final issue Date	Assurance provided	BAF/CRR Assurance	Clinical/ Internal Audit
NTW1617 46	IGT	27.04.2017	Substantial Assurance	SA1.7	IA
NTW1617 21	Information sharing with commissioners	27.06.2017	Substantial Assurance	SA1.7	IA
NTW1617 23	Joint working arrangements	27.06.2017	Reasonable Assurance	SA1.5	IA
NTW1617 36	Responding to Tenders	27.06.2017	Substantial Assurance	SA4.4	IA
NTW1617	Quality of impact of FDP	27.06.2017	Substantial Assurance	SA1.1	IA
NTW1617 34	MHA Section 136	27.06.2017	Good Level of Assurance	SA5.2	IA
NTW1617 33	MHA section 17	27.06.2017	Good Level of Assurance	SA5.2	IA
NTW1617 08	Positive & Safe & Overarching Clinical Risk	04.04.2017	Good Level of Assurance	SA5.4	IA
NTW1718 39	Central Alerts System	12.09.2017	Substantial Assurance	SA5.4	IA
NTW1718 09	CQC Process	18.10.2017	Substantial Assurance	SA5.1/SA5.2	IA
NTW1718 36	Monitoring Sickness absence	11.10.2017	Reasonable Assurance	n/a	IA
NTW1718 21	PFI Contract Monitoring	03.10.2017	Substantial Assurance	SA1.6	IA
NTW1617 55	Q4 Server Testing	18.09.2017	Good Level of Assurance	n/a	IA
