BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

TRUST BOARD TO BE HELD ON WEDNESDAY 25 MARCH 2015

BOARD ASSURANCE FRAMEWORK

Strategic or Regulatory Requirement to which the paper reports – to be a well led, effective and informed organisation, demonstrated by achieving the annual plan.

ACTION:

The Board are asked to approve the Board Assurance Framework.

Executive Summary

The Board has previously reviewed and approved the Board Assurance Framework quarterly, with Integrated Quality Committee reviewing the operational risks. Any operational risks which exceed a residual score of 12 are fed through to the Board Assurance Framework (BAF).

Following a review into the effectiveness of the Audit Committee on 21 July 2014, it was agreed that top risks would be reviewed by the Audit committee which received the last report at its February meeting.

Board Committees continue to regularly review risks and ensure that these are addressed, with assurance being gained by either incorporating work in the Committees' programme or receiving written reports. Any residual risk that is higher than 15 requires that a more detailed briefing is prepared with confirmation of actions taken to address the risk.

Appendix 1 identifies the risks from the risk registers which exceed a residual risk of 11 and have been incorporated in the BAF at appendix 2. There are 2 risks identified as 15 or above, which are

- Director of Operations (NEW): Risks to quality of care at Newbridge House arising from staffing issues and recruitment.
- Resources: Savings schemes not achieved.

When presented to committee it was agreed that the risks in relation to Newbridge House should be reviewed by the Integrated Quality committee and this action has been approved by Trust Board.

The Executive Director of Resources has agreed to review the risk level identified in relation to Saving schemes as this is believed to be lower risk than originally reported.

Recommendation:

The Board is asked to note and approve the current Board Assurance Framework.

BOARD DIRECTOR SPONSOR Deborah Lawrenson, Company Secretary

REPORT AUTHOR: Peter Hughes Associate Director of Governance

APPENDIX:

Appendix 1 – Residual risks exceeding a score of 11

Appendix 2 – Board Assurance Framework.

PREVIOUSLY DISCUSSED:

Trust Board,

Executive Team

Appendix 1 Residual Risks exceeding a score of 11

AREA	RISK: (score 15 / 16)	CONTROLS	ACTIONS TO BE TAKEN	Strat ref
RES: Fin	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a fall in financial risk rating or inability to fund capital programme	Savings Board now set up to monitor delivery through the year, and to provide oversight of new schemes being developed for future years. Meeting fortnightly at present and reporting to PMB.	Monitoring through savings board	2
RES: Perf Inf	Gaps in corporate reporting and reliability of information processes due to services using clinical systems other than RiO without sufficient resources being committed to overcoming the extra data management challenges involved	Information Asset Ownership (IAO) processes place a duty on services to manage systems effectively. Duty to audit KPI reporting processes where affected	Review of policy around corporate reporting and separate clinical application systems as part of information strategy development. Strengthen data quality duties of information asset owners as part of data quality policy review.	

CORPORATE RISKS RISK SCORE 12

AREA	RISK:	CONTROLS	ACTIONS TO BE TAKEN	Strat ref
HR	Prolonged 'time to recruit' over set target of 45 days, having an impact on ability to recruit quality staff in a timely manner	Defined recruitment time to recruit target set and processes in place	Corporate recruitment campaign. Additional recruitment resource. Revised recruitment and selection policy. Enhanced partnership working with operational services	4
HR	Failure by operational areas to complete effective staffing rosters in a timley manner (in line with trust requirments) leading to over reliance on TSS workers.	Operational managers required to monitor rosters to ensure timley completion	TSS working group established and chaired by Operational managers. TSS guidance revised; transfer of line management of e rostering team into HR.	4

HR	Security and IG risk identified through access rights given to temporary contractors where no clear end date is identfied.	Review of existing control measures and revise as appropriate to provide assurance.	Revised arrangements agreed between HR, Finance and ICT for engagement and termination of contractors (including systems access) in place	
MD	Risk of inadequate physical monitoring during an episode of rapid tranquilisation leading to greater risk of serious harm or death	Promote rapid tranquilisation policy RT training Emphasise use of RT form including physical monitoring and side effect monitoring plus service user follow up RT audits	Raise at local CGCs. Ward discussions.	1
MD	Risk of no acute inpatient beds available, leading to no bed available for emergency admissions and increased out of area placements	On-going daily review and management of acute inpatient beds	On going negotiations with commissioners concerning increasing inpatient beds and managing persons in crisis, 24hr acute day centres	1
RES Inf Gov	The Trust is issued with a monetary penalty notice by the Information Commissioners Office which has both a financial and reputational impact following a complaint or investigation.	There is little the Trust can do once an incident has occurred to prevent a fine if the ICO determines this action. Can ensure the incident is managed appropriately internally though.	ICO audit- follow up on recommendations	2
RES Inf Gov	Lose some control of Trust data as held in increased number of peripheral systems to RiO which are cloud based/ 3rd party systems and do not meet the same standards as the NHS.	Require IG Toolkit assurance from suppliers prior to signing a contract and exchanging personal data.		1
RES: Bus Dev	Other resources: Risk around operational and corporate staff ability to respond to a tender given day jobs and other priorities. There is also a risk of tender fatigue where tenders come in quick succession.	- each tender we complete a resource estimator both economically and financially. This is reviewed by Execs for every single tender allowing resource needs to be known and reviewed in advance	Ongoing monitoring	2
RES: Fin	Reduction in income from loss of 0-25 tender is not yet agreed. If final agreement exceeds £14.7m, loss of	Income estimates based on 13/14 activity are largely agreed. HTT, crisis houses and Acute Inpatients to be agreed	Final negotiations with Commissioners over Acute, Crisis and HTT service income values	2

	surplus could be greater than the £1m anticipated			
RES: Fin	Full reduction of costs due to loss of business cannot be fully realised	Expenditure reviews being done to assess where direct, indirect and overhead costs can be reduced and identify alternative uses for buildings which cannot be fully vacated.		2
RES: Fin	Potential reduction in income due to commissioners commissioning intentions/demand management/ desire for reconfiguration	Monthly monitoring of activity; contract review meetings with commissioners; joint working on service redesign	Continued liaison and joint working with commissioners; GP engagement strategy	2
RES: IMT	Risk of Trust PCs (2377) exposed to security vulnerability due to remaining on Windows XP	Replace or update all PCs to Windows 7 operating system	On going project to replace XP endpoints and upgrade the remaining by software refresh., Due for completion March 2015	2
RES: IMT	Demand for clinical systems training exceeds capacity and skills of training team causing unacceptable delays in delivery of training and subsequent delayed access to systems which could result in staff not being able to meet standards for timeliness of data entry and possible clinical risk.	Training resources are allocated appropriately and costs are identified in project planning for additional short-term resource to alleviate pressure.	Monitor requests for training and prioritise clinical need over personal development / skills technology training	4
RES: OD	The magnitude and uncertainty of re-organisation meaning that current work may not deliver against areed outcomes and commissioning new work becomes more complex	Regular updates with sponsors and attempt to "future proof" activity		4
RES: Perf Inf	Data quality assurance processes not sufficient to meet Monitor standards for FTs	Staff training in system use, automated report production, comparison of monthly figures to previous months, scrutiny of quarterly figures by Director of Performance, data quality flags published against indicator lines on Trust performance reports	All KPIs reported to Trust Board were audited during 2013/14	1
RES: Perf Inf	Information Team unable to provide a responsive reporting service to the	Prioritisation scheme sponsored by Exec Director of Resources, concentrating on priority 1 requests	Additional staff are currently being recruited.	4

	Trust and external stakeholders due to demand exceeding available capacity	only	Improve ability of analysis team to meet requests quickly and efficiently. Also improving / increasing self-service possibilities for Trust staff:	
RES: Perf Inf	Commissioning reporting requirements for new contracts and tenders outstrip Team's capacity to meet contractual reporting requirements on existing contracts	Time spent on meeting commissioning requirements is monitored within the Information team. There are detailed discussions with Commissioning colleagues to ensure analysis time "costs" are taken into account before new commitments are agreed. We are turning down most commissioner requests for new information.	Agree a reporting and resourcing model for supporting new contracts	3
DN	Capacity of Safeguarding team to meet requirements and ensure safe practice.	Safeguarding team / procedures	Additional staff agreed to be recruited.	4

OPERATIONS RISKS RISK SCORE 12:

HMP	There is a risk that the failure of adequate supervision and collection of prisoners at/for hatches will impact on delivery of medication in a timely fashion and possibly result in diversion of high profile medication, risk of patient on patient assualt, and the physical and verbal abuse of staff.	Daily report to duty manager to report any issues to daily operational meeting attended by prison governor, attendance at security meetings and SMT, attendance at partnership board, highlighted at medicines management meetings. Continued daily updates to prison, highlighted to commissioners in CQRM, reported in monthly SMT meeting, reported at quarterly prison partnership board, Staff are advised to close a hatch if it is unsafe. All violence/abuse problems at hatches are discussed at Start the Week meeting	Notice to be issued to prisoners about the need to attend the hatch during its opening time as failure to do so may result in not receiving medication. Plans to split the hatches on B wing between IDTS and B3 to reduce the pressure on the number of medications within time frame especially on evening hatches	1
HMP	There is a risk that failure to adequately assess prisoners on arrival at HMP Birmingham, due to large numbers and limited time can	Daily report to prison governor, update to morning meeting, Eclipse raised for patients not seen. Raise with commissioners for NOMS input	An audit arising from the homicide report will focus on the 24 hour follow up for prisoners identified with mental health	1

	result in inadequate assessment of their physical and mental health needs and associated risks		concerns at reception. This will be done Jan/Feb 2015	
HMP	There is a risk that the delay in obtaining G4S/NOMS clearance to ensure prompt start dates for new staff will impact upon the staffing levels within HMP Bimringham Healthcare and could result in an impact on the quality of care.	Weekly report to prison director, weekly check of position. Ensure staff fill all necessary paperwork out at interview to reduce timescales. Staff continue to work flexibly to provide cover. Raised with commissioners and NOMS seeking support in reducing clearance from a G4S perspective.	Plans to undertake an audit to monitor clearance delays and provide evidence to aid discussions with NOMS	1
HMP	There is a risk that the failure of released prisoners being picked up by appropriate community mental health services can result in an impact on their mental health and may result in a risk to themselves and/ or others	NTS on management of referals to community services HMP healthcare will plan for discharge for all pts in advance but CMHT staff need to maintain contact and communication channels for pts who they have CPA ownership of with HMP when a pt is serving a custodial sentence	This is an action arising from the recent homicide review. HMP Healthcare will routinely plan for release in advance. Need to agree a pathway for referral to BSMHFT for prisoners who are suddenly released. Need to agree with prison, policy of release dates.	1
MSOP	By complying with NICE guidance there is a risk of increasing the spend on scanning, which is not currently funded.	• CMB advised clinicians to comply with NICE guidance when considering scan request. • Work underway to reassign scanning costs to teams who will scan most [i.e. BMAS]. • Division to analyse data re scanning requests. • Trust procurement for new SLA underway need to monitor clinical compliance alongside available budget.	• Task and finish group to report to commissioners Dec 15, includes costing's exercise for current and future model.	1
SCC	There is a risk that the service will fail to achieve financial savings in line with set financial balance targets. This will result in additional cost pressure to the Trust that will impact on the Trusts overall savings target.	•Standing financial instructions; •Active budgetary control within all departments; •Active monitoring of contract performance; •Vacancy review •Strategic plans in place involving Development of Forensic service pathway •PMO initiative in situ	•The programme have identified savings and partially delivered because of other operational pressures and demands. •Regular monthly review of progress on savings and CREs schemes held at Programme monthly business meetings • Programme to identify savings, promoting efficiency and effectiveness.	2

			Review of contract details ensuring understanding by SMALT. •Regular monthly review of budgets led by SDM's and allocated forensic services accountant. •Use of PODS to plan and manage savings schemes	
SCC	There is a risk that planned move of Japonica on to the Ardenleigh site within the secure perimeter (using Baker unit) will cause increased risks in both the management of significant increased clinical acuity and in ensuring the integrity of the medium secure site in terms of physical and procedural security. This plan will result in considerable pressure on the Ardenleigh site to manage the safety of patients and staff and maintain the forensic standards to ensure no increased risk to the public.	Separate entrance agreed by Trust board to be added onto Baker ward prior to transfer of Japonica. Working group developing policies and procedures to protect the integrity of the building to maintain MSU Standards. NHS England & CQC are being consulted on changes. Comprehensive CQEIA completed and is available to view. DOSSN's to be taken out of numbers across site to better facilitate management of incidents.	Concerns raised via project group, directly to Trust board by letter and on Trust wide meeting agendas. Further discussion required to assure clinical staff that acuity will be managed through control measues introduced in a timely manner. Operational/clinical group established across whole site to review procedures and ensure mitigation factors are implemented.	1
SCC	Lack of seclusion facilities in Ardenleigh Women's service placing staff at risk from violence and patients at risk from prolonged restraint	Nursing and medical review of all pre-admission and consideration given as to whether seculsion is required	• Locks on extra care rooms can be altered to lock from the outside. • Refurbishment of seclusion suite to make it fit for purpose.	1
SCC	There is a risk of incomplete clinical records cause by the difficulties and limits placed on scanning documents (word and PDF) to RiO. This may affect risk management, or physical health problems, as key information can potentially be missing from the	Accessibility of the U drive allows for the storage of any service user documentation that cannot be uploaded to RiO within the Men's Service.	•All service user documentation, not on RiO, provided in hard copy and stored within the ICR – Head of ICR •Clarification from the relevant department regarding IT solutions as soon as possible – Head of IT •The use of the Reaside Forensic Admin	1

	electronic record, and could lead to a serious clinical incident. This may affect risk management or physical health problems, as key information can potenitally be missing from electronic record, and could lead to a serious clinical incident		drive to be included in local induction - Matrons	
SCC	There is a risk that shifts will be unfilled caused by TSS inability to fill shifts when additional staff are requested, leading to increased risk in clinical areas for both service users and staff including the possibility that essential clinical activity will be compromised.	•Review of rota's – assurances from ward managers re efficient rota management. •High level liaison with TSS and HR in identifying additional staffing arrangements. Eg block bookings & further recruitment. Weekly meetings with TSS & HR. •Identification of high risk shifts. •Advance booking of additional staff – block bookings to fill any vacancies. •On going review of levels of clinical activity via bed management and incident reporting. •Robust on going recruitment process for substantive posts	Clarification from the relevant department regarding IT solutions as soon as possible – Head of IT. •Review of rotas on a daily basis by Ward Managers and reviewing the next 24 hours	4
SCC	There is a risk that Forensic services will be unable to recruit and retain the appropriate staff which will result in patients not receiving the appropriate high quality care we aspire to. There is a current lack of band 5 nurses available with central recruitment processes only yielding 1 or 2 appointees per month.	•On going recruitment programme coordinated by the CNM's across the programme, including regular discussion with Satpal Gill and dedicated secure services adverts being placed via the central recruitment process. • Dedicated HR personnel in place supporting the recruitment process.	•Ward managers reviewing establishment figures on a month by month basis. •Robust selection process in place - led by discipline specific leads. •Action plan developed and SMART objectives formulated to support maintenance of staffing levels. •On agenda as standing item for evaluation at CG and SMALT meetings. •Recruitment process has been reviewed to ensure satisfaction that the standards to which we are recruiting to, are fair, equitable and will result in appropriate selection. • Staff will receive appropriate induction	4

			and training to enable them to undertake their role. •Interview panels will provide clarity of the role and requirements of the job. •Clinical Supervision will be promoted as a support to recruit developing into their new role.	
SEC	There is a risk that due to lack of bed availability service users will experience an undue wait for admission	Review of existing inpatient group to identify early discharges HTT review options of care i.e.. Respite, family support is available etc. Use of private beds where risk is escalated	To review each case individually and escalate concerns as needed	1
SOL	(Risk Identified Dec 2012) There is an increased risk of having to **employ outside agency staff** resulting in increased costs, due to difficulties accessing temporary staffing. This is due to reconfiguration of the availability process. There is a risk of inadequate staffing levels especially during the working week on the wards and all other clinical areas including HTT, NAIPS and CMHTs., which impacts on clinical care, increases the risk of complaint and impacts on the moral and stress of a significant number of staff. To date **ECT** treatment and section 17 leave have had to be cancelled due to inadequate staffing.	There is a trust wide group with senior staff and TSS actively involved. Staff from Solihull continue to contribute to this work.	Further recruitment has taken place, but some areas still experience a shortfall. Dee Roach is continuing to address the outstanding issues. Following a meeting 19.11.12 a working group has been formed to focus on resolutions to the issue. 4.11.13 There continue to be significant gaps in the TSS fill rates, and staff continue to work below established numbers. This has the potential to impact on clinical care and result in complaint. 08.01.14 Natalie Willets has reported back from a short life group that the potential has been identified for us to use another agency to assist with staff. 2.4.14. The trust wide group is continuing and Solihull staff are continuing to participate in this. Fill rates don't appear to have improved as yet. 5.6.14 Issues are on-going. Risk score discussed and to remain at 12. Oct 14 - Eclipse figures are reducing,	4

			although staff continue to report problems. To triangulate the data with the staffing levels board and review in IQ.	
SOL	Effect of hospital rennovations on Bruce Burns. Solihull Hospital have begun rennovation works on the ward above Bruce Burns. This will have an extensive impact on Bruce Burns as it will include work in the roof space of Bruce Burns. Difficulty managing the impact of the work has been compounded by a lack of clear information on the exact work plans and when each phase will take place. The rennovation will take 9 months in total.	An initial health and safety review has taken place and meetings with Solihull Hospital have commenced to try and ascertain more information. Initial plans may include closure of some beds / the ward.	Furthe meetings have been planned with all stakeholders and concerns have been escalated.	1
	Across the entire unit, there are multiple doors and door locks malfunctioning. This results in doors jamming open and closed, doors not swinging shut, keys breaking in locks and extra care timer function locks not always working. Thr risks are staff and young people being trapped in a particular area, young people being able to abscond, delayed responses to alarm activation, limiting options to evacuate. If necessary for example in a fire and young people accessing areas of clinic such as nursing office, clinic rooms and kitchen.	Issues are being reported to Estates who remdy problem in short term. Issues have been escalated to Estates Manager locally. Corporate Estates informed and working to support unit and reporting to Trust's Operational Director. Architect for unit has been informed and due to attend on 13.01.15		1

Service area key:

MD = Executive Medical Director
RES = Executive Director of Resources
ND = Executive Director of Nursing
SCC = Secure and Complex care
SOL = Solihull
HMP = Birmingham HMP prison
MHSOP

BOARD ASSURANCE FRAMEWORK

STRATEGIC AMBITION: Continuously improving quality by putting patients at the heart of everything the Trust does to deliver excellence. This will be measured by; Consistency of outcomes Clinical outcomes & effectiveness Safety outcomes Patient and carer experience

Trust Objective 1:	**Quality: Safety, Experience and Effectiveness** • Consistency of outcomes • Patient and carer experience	• Clinical outcomes and effectiveness • Safety outcomes
Risk of Non compliance	• CQC Non compliance • Trust reputation (eg Patient Survey) Specific risk arising from high profile cases/inquests • Loss of contracts • Failure to win new business • Lack of acute inpatient beds, leading to riskier management in community or out of area placement • Patients being placed on units less familiar with that Client Group, with less knowledge of risks/other issues • Failure of IT infrastructure	• Failure to comply with Monitor Quality Governance framework – particularly to implement unified quality / performance dashboard. • Increase in litigation costs / complaints / non valued adding activity • Failure to deliver CPA requirements • Safeguarding Review identified issues
Key Controls	• CPA action group • PMO – Transformation process • Identifying minimum staffing levels • Themes and trends in complaints or feedback	• Eclipse incident reporting (monitoring)
Committee review	• Integrated Quality Committee • Programme Management Board (Quality Impact of major projects)	• Learning against SI recommendations
Positive assurance	• Improvements recorded in patient survey • Board Quality Reports • ICR (Completeness audit results) • Daily review of bed state • Audit on staffing levels • Real time feedback • Outcome measures	• Incident reporting levels (NRLS benchmarking) • Review of Quality Goals in Business Plan/ Balanced Scorecard • External inspections • Safeguarding review

Gaps in Assurance	**Mitigating actions**
• Variability of audit and quality data across teams • Quality of information presented to demonstrate quality • Some CQC reports	• Quality Surveillance process / QST visits • Action plans from external visits
Key risks	**Mitigating actions**
• Ineffective team working leads to significant variation in practice • Failure by teams to address learning from previous audits • Variability of service standards • Failure to comply with policies/professional standards	• Actions to strengthen learning lessons process. • Improvements to monitoring and surveillance data • QST visits, service monitoring • Professional lead audits

• Unplanned disruption of IT infrastructure • Data quality • Bed pressures / seclusion facilities • Record systems – scanning • HMP Birmingham interface issues impact on clinical care	
Financial Impact **Assurance:** The above plans are within current budgets	**Responsibility:** Executive Director of Nursing

STRATEGIC AMBITION: Achieve long-term financial stability by: Being top quartile for productivity. Consolidation and protection of current business. Growth by acquisition or merger FRR of 4, discipline and rigour

Trust Objective 2:	**Finance and development** • Revised savings target of £10.5m • Retain current business • Develop savings plans for the next 3 years • Expand current service provision within agreed parameters	• Achieve financial surplus • Deliver and track savings and surplus • Corporate services value for money • Recovering anticipated income
Risk of Non compliance	• Increased focus on finance detracts from focus on Quality • Short term savings required to bring financial balance back • Long term viability threatened by decreasing margins • Reduced Monitor risk rating leads to increased regulatory activity	• Rising cost pressures, e.g dementia drugs • Inability to maintain bed occupancy • Reduction in education and training monies • Inaccurate data
Key Controls	• Business Development unit	• Project Management of savings plans
Committee review	• Planning and Development Committee • Integrated Quality Committee • Programme Management Board	Audit Committee
Positive assurance	• Current Surplus • Savings plans for future years • Audited Accounts 2013/14 • Finance report (April)	

Gaps in Assurance • Benchmarking on productivity and corporate services • Pricing Policy	**Mitigating actions** •
Key risks • Failure to deliver savings schemes • Reductions in income not compensated by expenditure reductions • Drugs Expenditure • Impact of 0 -25 tender • Change in Monitor Risk Assessment Framework • Loss of tenders for either existing or new services • Redundancy costs arising from successful or unsuccessful tenders • Financial penalties – eg Information governance • Ability to respond to tenders	**Mitigating actions** • Regular reviews and forecasts
Financial Impact Assurance: Potential for financial position to deteriorate	**Responsibility:** Executive Director of Resources

STRATEGIC AMBITION: 3. Develop strong, effective, credible, sustainable relationships with key stakeholders, building the Trust's reputation

Trust Objective 3:	**Reputation and Engagement** • Excellent commissioner relationships • Implement the stakeholder approach • Improve engagement with service users and carers • JV opportunities	• Develop effective partnerships with current and potential third sector partners • Build effective relationships with Community Services and Social Care
Risk of Non compliance	• Loss of contracts • Not becoming integral part of local health economy • Specific contracts at risk of non renewal or underperformance x 3	• Impact of changes to local commissioning groups/NHS England • Financial cuts impacts on commissioning decisions
Key Controls	• Clinical Quality review group • Individual relationships	• Contract management structure
Committee review	• Integrated Quality and Primary Care Board	
Positive assurance	• GP Engagement • Customer Relationship Management Tool	

Gaps in Assurance • Impact of Trust response to 0 – 25 decision.	**Mitigating actions** • Transition plan and Quality impact assessment
Key risks • Impact of quality issues (risks re Ambition 1). • Variability of GP and increasing variation of CCG intentions. • Ensuring co ordination of all relationships with stakeholders • Not anticipating commissioning requirements • Failing to be responsive to changing market • Meeting commissioners reporting requirements	**Mitigating actions** • Meetings with commissioning teams
Financial Impact **Assurance:** Loss of income	**Responsibility:** Chief Executive

STRATEGIC AMBITION: To have a workforce that is innovative, empowered, engaged, fairly rewarded and motivated to deliver the strategic ambitions of the **Trust. Evidenced in the staff survey feedback**

Trust Objective 4:	**Staffing, leadership and development** • Improve management and clinical leadership capability • Review of critical supply pressures • Working better together • Appropriate staffing levels	• Reduce number of staff who feel discriminated against. • Staff engagement • Modify staff terms and conditions for savings
Risk of Non compliance	• Failure to recruit adequately trained staff • Litigation • Risk of non compliance with CQC registration caused by insufficient staff or inadequate skill mix • Inadequate job planning processes in place	• Low staff morale • Disruption caused by immature operational structure • Fail to comply with workforce checks
Key Controls	• E rostering • HR recruitment processes	• Implementation of Leadership Strategy
Committee review	• Integrated Quality Committee (Quarterly report) • Work force committee	
Positive assurance	• Staff survey results • Improved staff retention rates	• Pulse surveys • Workforce report

Gaps in Assurance • Impact of bullying and harassment policy • Number of grievances	**Mitigating actions** • Review policy and new advice guidance on connect • AD in HR to have learning lessons plan
Key risks • Ability of temporary staffing to meet Trust requirements • Staff survey results do not improve • Failing to ensure adequate employment checks are undertaken •	**Mitigating actions** • Review of TSS requirements • Action plan response to internal audit report
Financial Impact **Assurance:** • Quality and clinical impact assessment • Resource and activity monitoring at OMT to Monitor	**Responsibility:** Executive Director of Operations