Appendix A Board Assurance Framework - Quarter 1 2018/19 * Target scores are for consideration and approval by Board of Directors

Ref	Risk Description *What might happen if the risk materialises.*	Current Context *What is the cause of the risk*	Risk Owner	Initial Risk (Ixc) *Without Controls*	Current Risk (Ixc) *With Controls*	Provisional Target Risk* (Ixc)	Existing Controls *What is currently in place to mitigate the risk*	Assurance *Evidence that the controls are effectively implemented*	Action Required *Gaps in controls or assurance*	Timescale to complete action
SR1/18	**Financial deficit significantly in excess of planned levels** Any material financial deterioration against the Trust's financial planmay result in: *Reduced 'Use of Resources' score which forms part of the NHS regulators measurement of providers. *Decrease in sustainability funding may lead to lower than planned income. *Requirement for additional financing may lead to increased costs. *Regulatory inervention may lead to constraints in decision makig by Board *Adverse media coverage may lead to reputational damage.	The year on year impact of national tariff efficiency requirements, combined with changes to contract rules (marginal rates, fines, penalties) has increased the financial pressure on all NHS providers. This risk may occur as a result of: *Higher than planned expenditure due to factors such as failure to meet CIP targets, increased procurement costs as a result of BREXIT, and contractual fines. *Lower than planned income due to such factors as the ability to meet operational targets, data quality issues and ability to take advantage of innovation opportunities.	CFO	**20 (5x4)**	**9 (3x3)**	**6 (2x3)**	* Trust Annual Financial Plan * NHS Improvement Annual Plan Return, monthly reporting to NHS Improvement and Board including CIP delivery expenditure and income *Internal policies and procedures *SFIs / Standing Orders. *Scheme of Delegation *Trust financial system (SAGE - QEHB and ORACLE - HGS) reflects the approved SFIs and Scheme of Delegation. *New financial reporting (HGS) * Key senior appointments made to finance team	Trust Annual Financial Plan approved by Board in April 2018 Internal: monthly financial reports to BoD, CEAG, CCQ meetings. Financial Improvement Group meetings with operational divisions (QEHB) CIP Steering Group (monthly) Bi-monthly exec performance reviews Head of Internal Audit opinion External audit / going concern assessment External: Annual Operational Plan documents submitted to NHS Improvement. External Audit reviews and Counter Fraud Service Assessment. External assessment of effectiveness of Counter Fraud Service assessed as adequate.	Support Internal Auditors with ongoing scrutiny and assurance Medical efficiency programme (focus on locums & job planning) Workforce redesign Roll out of SLR and Patient Level Cost Benchmarking (Albatross) to identify further efficiency opportunities	Ongoing
SR2/18	**Cash flow affects day to day operations of Trust** If the Trust cannot maintain a sufficient cash balance this may result in: *Delayed payement of staff salaries resulting in increased staff turnover and decrease in morale. *Requirement to source additional funding which may lead to increased costs and regulatory pressure. *Delayed payment of invoices to suppliers may stress the supply chain and affect our ability to procure goods and services. *Adverse media coverage may lead to reputational damage	This risk may occur as a result of: *Higher than planned expenditure due to factors such as failure to meet CIP targets, increased procurement costs as a result of BREXIT, and contractual fines. *Lower than planned income due to factors such as the ability to meet operational targets, late payemnt of invoices by 3rd party and other NHS providers, data quality issues and ability to take advantage of innovation opportunities.	CFO	**15 (5x3)**	**12 (4x3)**	**6 (2x3)**	* Trust Annual Financial Plan * Weekly cash meetings to manage cash flow and discuss cash management measures * Working capital loan agreed in principal	Trust Annual Financial Plan approved by Board in April 2018 Cash positions reports to Board (quarterly) SFIs / Standing Orders Scheme of Delegation Monthly financial return for cash balance and cash forecasts reported to Board **External**: Monthly financial return for cash balance and cash forecasts reported to NHSI	Workforce alignment Over 90 Day debt recoup EY actions and recommendation being implemented	Aug/Sept
SR3/18	**Prolonged and/or substantial failure to meet operational performance targets.** Failure to achieve performance targets for the following: * Cancer 62 day * Breast 2ww * Cancellations due to either capacity constraints on wards or transplants * RTT * 4 hour ED target Financial delivery of CIP Prolonged and/or substantial failure to meet these targets may lead to: * Unintended harm to patients which may result in increasing number and severity of incidents and claims. * Below standard patient experience which may lead to complaints * Adverse media coverage and reputational damage. * Regulatory action may lead to loss of licence or service and constraints in decision making by Board. * Financial penalties incurred and loss of income may lead to unfunded expenditure.	The main factors that effect the ability of the Trust to deliver operational performance targets are: * Demand for services exceeds the Trust's capacity. * Out of area referrals (Cancer pathway and RTT) * Inappropriate ED attendances due to perceived/actual lack of community provision * Timeliness of tertiary referrals (referrals received after breach) * Out of hours staffing rotas (rotas not meeting demand)Difficulties with patient flow	COO (QE and HGS)	**25 (5x5)**	**20 (5x4)**	**9 (3x3)**	Unscheduled Care Project has been reviewed and strengthened. Action plans to address capacity shortfalls (unscheduled care and cancer) Action plan to mitigate issues effecting 18 week RTT Specific pathway reviews Review demand from out of area referrals and put in place appropriate action(s). Activity Reviews. Short, Medium and Long Term Plans. Quarterly reviews of activity and growth. In addition at HGS - Improvement plans and Groups established for urgent care, length of stay, scheduled care, financial recovery and CIP.	**Internal:** Performance against national targets and waiting list size - performance reports to COOG, CEAG and BoD 18 Week RTT Assurance Group meets to assess whether targets are being achieved as well as reviewing and updating action plan Cancer Services Steering Group (breast and cancer) Cancer Waiting List Assurance Group meets weekly and reviews the data to assess capacity, performance, waiting time targets, and review action plans which reports to the Cancer Steering Group and COOG. Short, medium and long term plans presented to the Executive teams by Divisions. **Internal:** CCQ papers and minutes **External:** Agreement with CCCCG and SCCCG. Communications. **Internal:** Monitoring figures for capacity via bed meetings and dashboards. Short, medium and long term plans. Weekly monitoring of the annual plan targets (activity, capacity and demand) through ODG. Specific remedial recovery plans and Task and Finish Groups COOG ODG fortnightly meetings The Newton Seamless surgery programme continues; the aim of the programme is to improve productivity within theatres. **External:** Regular contact is maintained with commissioners via phone and email to ensure any concerns are addressed. Also monthly Strategic resilience Group meetings (including Clinical Subgroup) and Contract Review Meetings **HGS** Monthly report to trust Board re operational performance Monthly report to Chief Executives group re operational performance Monthly updates on progress of work streams Regular divisional performance meetings	Divisions working to implement the revised capacity requirements. The plans are reviewed ongoing and cross divisional actions are monitored at the fortnightly operational delivery group (ODG). Actions within the Integrated Performance Report to continue to be implemented to enable the Trust to meet the trajectory agreed with the commissioners HGS Delivery of plans within the relevant improvement groups.	Ongoing

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SR4/18	**Increasing delays in transfer of care from UHB sites in excess of agreed targets** Delays in the transfer of care for patients may result in the following imapct and consequence: *Pressure on patient flow which impacts on quality of care and patient experience. *Requirement to increase capacity on an ad hoc basis may lead to increased cost. *Adverse media coverage may lead to reputational damage. *Longer waiting times may lead to missed operational targets. *Capacity to admit new patients may lead to patient safety issues. *Missed operational targets may lead to loss of income and financial penalties.	Delayed transfer of care may be caused by: *Patient and relative choice. *Capacity in nursing and residential accommodation. *Delays in availability of care packages. *Awaiting completeion of internal and external asessments. *Awaiting the provison of care by other NHS providers. *Awaiting Mental Health ongoing care.	DOP	**25 (5x5)**	**20 (5x4)**	**9 (3x3)**	*Alternative sources at HGS to prevent delays to discharge and systems in place to ensure this capacity is effectively managed i.e. Supported Integrated Discharge (SID), Recovery at Home (R@H) et al. *Conference calls with partners escalating delays and quality concerns for resolution by partners. *Internal Monitoring and Management of patients referred for social care intervention and CHC nursing assessments via hospital discharge hubs overseen by senior managers from the council and Trust. Daily board rounds. *Weekly escalation meetings in place with Director of Partnerships and the Director of Corporate Affairs to try to resolve complex cases. *Monthly hub meetings in place for senior managers to review performance and monitor internal action plan. *Senior Trust managers involved in STP system project teams looking at development of early intervention services and improving fast track and continuing healthcare processes. *DTOC performance on BSOL A&E Delivery Board agenda. *Chief Executive Officer corresponds frequently with NHS Improvement/Monitor/CQC.	Birmingham wide daily capacity reports. Minutes of (Birmingham & Solihull) BSOL A&E Delivery Board, and the Early Intervention Social Care & Health Integration Meeting. **Internal:** Discharge Hub established. At QE electronic tracking system with daily board round records for each patient and agreed actions. Relevant Executive & Operational Groups RRR Project agendas/minutes, Papers and minutes of the QE Unscheduled care group. BoD performance papers and minutes **External:**BSOL A&E Delivery Board papers and minutes. BSOL Birmingham Ageing Well Board papers and minutes. Newton system diagnostic analysis and findings November 2017. STP Board papers and minutes February 2018. **Internal:** Feedback from Executive meetings with Government leads to establish influence over policy and strategy.		
SR5 18	**Unable to meet the requirements of the Trust's staffing model** If the Trust cannot recruit, control and retain adequate staffing then this may lead to: *Impact on quality and patient experience which may lead to formal complaints and CQC intervention. *Unintended harm to patients which may result in increasing number and severity of incidents and claims. *Inability to meet financial targets which may lead to unfunded expenditure. *Adverse media coverage and reputational damage. *Adverse effect on staff morale leading to increase in absence and retention difficulties. *Spending above planned levels that may lead to pressure on control total. *Ability to meet legislative requirements relating to staffing may lead to financial penalties.	Inability to meet the Trust's staffing model may be caused by: *Ability to recruit sufficient numbers and skill mix of staff. This is made worse by national shortages, the effect of BREXIT uncertainty on EU staff and adverse media coverage which may make the Trust seem a less attractive employer. *Compliance with policy and procedures that enforce standards of employment and required ways of working. *Retention of staff who are in post.	EDWI	**20 (5x4)**	**16 (4x4)**	**12 (3x4)**	*Recruitment plans for clinical professions. 2018/19 Workforce planning return submitted to NHSI / HEE. *Workforce policies and procedures *Retention Strategy *Leadership and management education programme established for middle and senior managers. *Talent Management champions trained and established with Talent Management embedded into revised appraisal policy (HGS) *Mentorship and Coaching freely available through leadership portal on the website. *Top Leaders programme available through NHS Academy with sponsorship for additional bespoke programmes identified. *Daily and weekly review of staffing levels and skill mix *Use of bank and agency with robust monitoring system and Exec sign off * Health and Well Being Initiative (QEHB) * Agenda for Change enhancements * Harmonisation of bank rates * enhanced use of social media for recruitment * International Fellows Programme * Cross-site working harmonisation	The Strategic Workforce group meets bi-monthly and provides updates to Trust Board and CEAG Medical workforce group chaired by Deputy CEO Reports to Board of Directors KPI evidence reports Staff survey Training records and ESR. Monthly Senior Team meetings with Divisions Monthly Junior Doctor Steering Group Audit Committee reports confirm the reliability of financial records and compliance with Trust policies and regulation Junior Doctor Taskforce Group (QEHB) Cross- Site Working Group	Implement Talent Management process at QEHB Implement Health and Well Being Initiative at HGS Exploiting the overall package including 18/19 wage increase to be incorporated as part of recruitment and retention communications Junior Doctor Taskforce Group to be rolled out at HGS Strategic Workforce Task and Finish Group for all Divisions to identify key groups for retention across the Trust Review of recruitment process to reduce delays Alignment of HR Workforce to ensure greater consistency and support to Divisional teams Review of IT Platforms at HGS Further rollout of Allocate at QEHB Review of Allocate at HGS	Q2 1819 Q2 1819 Q3-4 1819 2019/20
SR6/18	**Regulatory Action** Where a regulator takes action against the Trust this may lead to any of the following: *Licence conditions which introduce constraints in decision making by Board. *Financial penalties incurred may lead to unfunded expenditure. *Adverse media coverage may lead to reputational damage. *Mandatory improvements may lead to unfunded expenditure.	Regulatory action may take place following a failure to adhere to statutory and regulatory requirements, national guidelines and audits and (inter-)national standards and accreditations (e.g. CQC, clinical audits, MHRA, HSE, UKAS, etc.) and threat to UHB sustainability and licence conditions.	DCA	**16 (4x4)**	**12 (3x4)**	**4 (1x4)**	Governance Declaration - The Board of Directors receives a draft annual report outlining the Trust's proposed annual governance declaration in March every year. This declaration is then signed off in the following May and submitted to NHS Improvement to ensure the Trust maintains compliance with its obligations. The annual Board paper is included as part of the Annual Business Cycle to ensure that the declaration is submitted in line with NHS Improvement's deadlines. Strategy & Performance Team Performance Monitoring Arrangements The Clinical Compliance Framework has been implemented within specialties as a way to provide assurance that areas are meeting the CQC's Key Lines of Enquiry (KLOE's). This includes specialty self-assessment. The Risk and Compliance Team continue to work with department leads to see how the organisation can collect data in the format required for the CQC's annual provider information request. The Clinical Risk and Compliance Unit has processes in place to: - manage national and local audits to ensure evidence shows compliance with that process. - manage incidents and identify trends. - manage new and existing NICE guidance to ensure there is evidence to show compliance and where we are not able to adhere to the guidance e.g. we do not provide the service, the medical director's approval has been obtained. - manage NCEPOD studies and identify actions, in conjunction with the clinical teams in response to the outcome of the relevant study. - Manage oversight of any external visits - Manage the QSIS specialised services peer review programme The Corporate Compliance Framework's purpose is to assure that required actions are being carried out by those who have that responsibility, and to alert/escalate appropriately when they are not. The Corporate Compliance Framework will allow the Trust to understand its Corporate Compliance position regarding legislation and regulatory requirements. It will also include actions from regulatory inspections. Annual health and safety inspections at local level Data Security and Protection Toolkit (previously known as the Information Governance Toolkit) Unannounced Board of Directors visits are arranged on a monthly basis and are led by either the Executive Medical Director or the Executive Chief Nurse	**Internal:** Board Meeting Minutes. Annual Governance Declaration **Internal**: Quarterly Board Meeting Minutes. Quarterly divisional performance meetings Contract review meetings Internal Audit Internal: Presentation at BOD seminar in May 2016 Quarterly compliance reports to BoD and Audit Committee. CQC external report DCA Group minutes Compliance Framework reports to DCQG meetings every quarter **Internal**: Quarterly compliance reports to BoD DCA Governance Group minutes National Audit presentation to CQMG Clinical Quality Monitoring Group (CQMG) Divisional Management Teams Health and Safety Executive Committee minutes Information Governance Group minutes Policy Review Group minutes DCQG quarterly compliance reports **External**: QSIS self-declaration	Approve the template for the Corporate Compliance Framework and begin to populate Implement and complete Phase 1 of the Clincial Compliance Framework at HGS Divisions	Q1 201819 Q1 201819

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SR7/18	**Failure of IT systems to support clinical services and business functions.** If the Trust's IT systems fail then this may lead to: *Service disruption which impacts on safety, quality and patient experience. *Adverse media coverage and reputational damage. *Adverse effect on staff morale leading to increase in absence and retention difficulties. *Loss of personal data that may lead to regulator intervention and fines *Decrease in data quality which may impact on income or ability to meet reporting requirements and may increase pressure on clinical staff.	Issues that may have an impact on IT systems include: *Appropriate skills and number of IT staff. *Cyber security attacks *Quality of IT infrastructure. *IT strategy not aligned to Trust objectives. *Failure of 3rd party providers. *Failure to sustain funding at an adequate level. *Malicious intent/staff actions.	MD	**25 (5x5)**	**6 (3x2)**	**4 (2x2)**	* Full Business continuity plans * Emergency Preparedness Policy and procedure * Service management processes in place. * Security standards and policies implemented. * Regular data backups and checks that the back-ups have integrity. * ISO 9001/ISO 27001 certified. * Recover Plans/Contingency Plans for critical systems * Workforce Plan * Quality Management System Telephone system replacement solution Data Centre is fit for purpose and has sufficient capacity A Health Informatics / Business Intelligence function is established	* Emergency Preparedness Steering Group minutes * Reports from table top exercises. * Documented and approved service management processes, * Architectural reviews of all system and infrastructure designs to ensure they meet compliance with industry standards. ISO 9001/ISO 27001 last LRQA Audit was 13th April 2018 - certificate maintained * Bi-monthly updates to IG group * Validation of table top exercises by an external auditor. ISO 9000 (HGS) * Monthly updates to joint Digital Healthcare Group * Change Advisory Group (weekly) (in the narrative we call this * Weekly RCA meetings to review Priority 1 RCAs * ISAG (monthly) * Cyber reports to Audit Committee (quarterly) * Monthly updates to Board of Directors via Medical Director * Monthly updates to Emergency Planning Group (for BCP) * Information asset owners to provide assurance with respect to BCPs	The maturity of our systems and capabilities of our people is constantly improving but we need further development to create a truly robust environment. Ongoing review of workforce recruitment and retention to inform QMS Manual (ISO9001:2015 7.2) Review of processes and rolling modernisation of technical security control Consolidation of policies and procedures Install PICS at HGS sites Additional Progress at HGS Network, wireless and telephone capital milestones work programme continues and is on plan IT to undertake gap analysis and develop necessary remediation plan including potential investment via business case. IT align technical controls to meet policy Informatics scoping work to be undertaken to develop appropriate investment case Analysis of information flows commenced ISO Audit and strategy to be developed to set out actions required for non-conformances.	2020 Dec 2019 2nd Aug 2018
SR8/18	**Adverse impact on Trust innovation agenda.** If the Trust is unable to maintain progress then this may cause: *Increase in procurement costs leading to unfunded expenditure *Limited access to European research networks *Inconsistent supply of products leading to adverse impact on quality of service *Delays in new products being developed and coming to market *Access to markets for new and current products *Ability to attract appropriate research staff *Migration system inhibit the free movement of scientists, researchers and scientific technicians *UK trials are no longer able to recruit European patients which would lessen the benefits for patients	The main cause of this risk is the uncertainty related to the future of funding and innovation frameworks as a result of BREXIT.	EDWI	**16 (4x4)**	**12 (4x3)**	**8 (4x2)**	*Membership of overseas research networks *Exploration of non-EU trials work *Strategic alliance through Birmingham Health Partners (BHP)who continue to lobby regarding Brexit uncertainty * Working with Pharma compainies to provide a premium service * Clarification of Tier 2 visa regime for doctors, nursing and high-tech staff	UHB Chair and CEO are members of the BHP Board and meet quarterly BHP Executive Board meet bi-monthly BHP Research updates to UHB Board 6 monthly Strategic Research Executive Group update the Board	Ongoing monitoring Continue lobbying	
SR9/18	**In-patient infections significantly in excess of agreed national levels** The Trust cannot exceed national levels in-patients infection which may lead to the safety of patient experience being compromised. This could further lead to *formal complaints/concerns made against the Trust. *decrease in patient flow and increase capacity and the Trust's ability to met national targets. *Regulatory intervention may lead adverse media coverage may lead to reputational damage. *Financial penalties incurred may lead to unfunded expenditure.	Factors that may affect our ability to controls infections are: *Increase in prevalence in community *Drug company's changing medication products *Lack of compliance with policy *New/resistant strains may arise	CN	**25 (5x5)**	**4 (2x2)**	**4 (2x2)**	* Policies and procedures *Infection Prevention and Control Policy *Health and Safety Policy * Procedure for Isolation * Pre Employment Checklist * Monitoring and surveillance undertaken * An MRSA action plan has been implemented has been put in place monitored by the IPC Group.	MRSA Action Plan monitored monthly by IPC Steering Group Monitoring and surveillance reported to Operational IPC Group Monitoring and surveillance reported to monthly IPC Steering Group IPC Steering Group reports monthly to Board. Patient Care Quality Group monlthy report includes Infection Control updates		
SR10/18	**Failure of commercial ventures** The Trust is a partner in various commercial ventures, both in the UK and abroad. Should any of these ventures fail the Trust may suffer: *Adverse media coverage and reputational damage. *Claims, financial losses and unfunded expenditure. *Regulatory action and constraints in decision making by Board. *Adverse effect on staff morale leading to increase in absence and retention difficulties.	The viability and sustainability of commercial ventures may be affected by: *Partner behaviours and culture. *Adequate management and oversight of ventures. *Market uncertainty (especially around BREXIT) *Increased competition *3rd party claims.	EDSO/DCA/CFO	**20 (4x5)**	**6 (2x3)**	**6 (2x3)**	Principles for investment include appropriate due diligence and a risk assesment upon entering into each venture. New contracts are routinely reviewed	Investment Committee papers. The group meets **every two months.** Corporate Affairs	The Director of Strategic Operations and External Affairs provides updates to the Investment Committee every 6 months on the progress of existing projects as well as any identified future opportunities.	Ongoing
SR11/18	**Merger has adverse effect on Trust** Now that transaction to merge QE and HEFT into a new organisation has taken place the realignment of services may have an impact on the following: *Service disruption which impacts on quality and patient experience. *Adverse media coverage and reputational damage. *Adverse effect on staff morale leading to increase in absence and retention difficulties. *Opportunities to improve service and business not fully realiesed leading to incresed cost and loss of income.	There is a challenge in managing substantial change and achieving a cohesive culture which recognises the best of predecessor organisations while aligning services to realise the opportunites. This may be caused by: *Unknown issues coming to light. *Differences in culture creating barriers. *Effectiveness of communications. *Capacity and capability to manage substantial change.	EDSO/DCA	**20 (4x5)**	**9 (3x3)**	**6 (2x3)**	Trust Integration Plan - next stage Due diligence completed as a part of the transaction Clinical and Corporate Compliance Frameworks Communications plan as a part of Trust Integration Plan	Monitored through SOSG Reported to board and regulators	Case for Change Closing Report to be presented to Board of Directors	Jul-18

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SR12/18	**Unable to maintain and improve quality and quantity of physical environment to support the required level of service** The current estate for the Trust may not be able to provide sufficient quality and capacity to support the services required, this could lead to: *Service disruption which impacts on quality and patient experience. *Longer waiting times and missed operational targets. *Adverse media coverage and reputational damage. *Adverse effect on staff morale leading to increase in absence and retention difficulties. *Opportunities to improve service and business not fully realiesed leading to incresed cost and loss of income.	The estate requires continual maintenance to meet the current service requirements and improvement to meet future need and realise opportunities. This may be difficult to achieve because of: *The poor quality of the current estate in some areas of the Trust. *Ability to meet requirements of maintenance program. *Funding for new capital projects. *Alignment of Estates strategy to meet future requirements.	EDSO	**25 (5x5)**	**16 (4x4)**	**9 (3x3)**	Scheduled Divisional reporting and monitoring Proactive risk management system to continuously measure and monitor risk and prioritise investment and allocation of resource. Comprehensive Planned Preventative Maintenance Programme that ensures the Estate, Plant, Infrastructure and Equipment is safe, compliant and utilised to its maximum capacity and full lifecycle. Reactive Maintenance SLA to ensure the Estates, Plant, Infrastructure & Equipment are returned to use in a timely manner. Priority risk based annual Capital Bids to improve the Estate and upgrade Plant, Infrastructure Equipment etc. Estates strategy and workforce model Customer satisfaction survey	COOG x 2 monthly Estates Department Performance & Assurance Framework Monthly Directorate Statutory Compliance Group Assurance Meeting Internal Audit Programmes External Accreditation to ISO9001 & ISO14001 standards Six Facet Property Condition Survey Funding agreed for current preparation work undertaken to date to develop ACAD building and associated utility infrastructure.	Clarification of Clinical Strategy/Clinical Needs. Determine which clinical services are to be provided from which site to balance use of the existing Estate Estate Strategy to be aligned with Clinical Strategy / Clinical Needs Significant investment in Estate Development to meet Clinical Needs and proposed development Full Business Case to be submitted for ACAD	TBC TBC TBC TBC Q3 201819