NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

# Board Assurance Framework and Corporate Risk Register

# 2018-19

**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 | **2** | 10 | **Low** |
| | Target Risk (after improved controls): | 5 | **1** | 5 | **Very Low** |
| | **Risk Appetite:** | **Finance/VfM** | | | **Within** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(actions to achieve target risk )** |
|---|---|---|
| 1. CEDAR Programme Board Established with key Partners.<br>2. CEDAR Programme Delivery<br>3. CERA Programmes<br>4. Business Case approved for interim solution for WAA and Newcastle/Gateshead. Building programme in place<br>5. ICS supported nationally and funding identified<br>6. CEDAR Business Case process in place | 1. Minutes of CEDAR Programme Board<br>1. Feedback/update via Sub Committees/board<br>2. CEDAR Documents<br>3. CERA Documents.<br>4. Business Case Document.<br>5. ICS Bid Document.<br>6. Business case cycle for board meetings.<br>2. NTW 1718 23 Capital Planning | 1. Asset sales identified - reporting through RBAC on progress to be commenced April 2019 |

**Ref:** SA1.2

**Review Comments: Residual risk score reduced from 5x3 to 5x2 due to actions being completed in relation to ICS bid outcome and building programme in place for Newcastle/Gateshead**

| **Executive Lead: Deputy Chief Executive** | **Board Sub Committee: RBAC** | **Updated/Review Date: January 2019** |
|---|---|---|

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** |
|---|---|---|---|---|---|
| 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 | **2** | 8 | **Low** |
| | **Risk Appetite:** | **Quality Effectiveness:** | | | **Exceeded** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(Actions to achieve target risk)** |
|---|---|---|
| 1.Integrated Governance Framework.<br>2.Agreed contracts signed and framework in place. for managing change.<br>3.Locality Partnerships.<br>4. Well led action plan complete.<br>5. All CCG contracts agreed. | 1. Independent review of governance-Process Amber/Green rating assessment.<br>2.Contract monitoring and contract change reporting process to CDT and RBAC.<br>3. Updates from Locality Partnership meetings<br>4. Well led action plan document.<br>5. Contract documentation. | 1. Move towards lead/prime provider models and alliance contracts by April 2019<br>2. Contract negotiations commencing for the coming year to ensure that consideration is given to impact on clinical care - April 2019 |

**Ref:** SA1.3

**Review Comments: additional action in relation to contract negotiations for the coming year has been added.**

| **Executive Lead: Executive Director of Commissioning & Quality Assurance** | **Board Sub Committee: RBAC** | **Updated/Review Date:** January 2019 |
|---|---|---|

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 journey to wellbeing.

| Principal Risk: | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| There is a risk that high quality, evidence based safe services will not be provide if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands. | Risk on identification (Feb 2012): | 4 | **4** | 16 | **Moderate** |
| | Residual Risk (with current controls in place): | 4 | **4** | 16 | **Moderate** |
| | Target Risk (after improved controls): | 4 | **1** | 4 | **Very Low** |
| | **Risk Appetite:** | **Quality Effectiveness** | | | **Exceeded** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(actions to take to achieve target)** |
|---|---|---|
| 1.Integrated Grovernance Framework.<br>2.Performance review monitoring and reporting incl compliance with standards, indicators,CQINN.<br>3.Operational and Clinical Policies and Procedures.<br>4. Annual Quality Account.<br>5. CQC Compliance Group.<br>6. Trustwide access and waiting times standard group established.<br>7. Waiting times dashboard. | 1.Independent review of governance against Well-Led Framework January 2016<br>1/2/4.External Audit of Quality Account<br>1.Operational Plan 2016/17 reviewed by NHSI.<br>2.Reports to CDTQ,Q&P and QRG's.<br>3. Compliance with policies reviewed annually<br>5. CQC review rated outstanding.<br>6. Minutes of access and waiting times standard group.<br>7. Monitoring of the waiting times dashboard. | 1. Monitoring and Delivery of Operational Plan 18/19<br>2. Delivery of 5 Year Trust Strategy 2017-2022 and supporting strategies.<br>3. Complete Access and Waiting times Standard Grou Work Plan.<br>4. Develop approach to access, waiting times, management of DNAs, discharge and patient flow.<br>4. Internal Audit 18/19 - please see audit plan. |

**Ref:** SA1.4

**Review Comments: No change this quarter**

| **Executive Lead: Executive Director of Nursing and Chief Operating Officer** | **Board Sub-Committee: Q&P** | **Reviewed: January 2019** |
|---|---|---|

**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** |
|---|---|---|---|---|---|
| If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an Organisation. | Risk on identification (May 2017): | 4 | **4** | 16 | **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. Joint Programme Board | 1. Minutes of meetings | 1. Ongoing dialogue with Trust Board - Monthly |
| 2. Due Diligence | 2. Due Diligence Report | 2. Identification of risks and mititgations by Nov-18 |
| 3. Exec Leadership | 3. Identified Exec Leadership | 3. Review of capacity to deliver by Nov 2018 |
| 4. Specific Capacity Identified | 4. Identified NTW Team | 4. NTW Trust Board to consider FBC in January 19 |
| 5. Clear Oversight by Trust Board | 5. Board Development Sessions | |
| 6. NTW Trust Board approval to go to FBC | 6. Minutes from Board meeting | |

**Ref:** SA1.10

**Review Comments: Action complete - Trust Board approval to go to FBC (to be taken at Trust Board in January 2019)**

| **Executive Lead: Executive Director of Commissioning and Quality Assurance** | **Board Sub Committee: RBAC** | **Last Updated/Reviewed: January 2019** |
|---|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

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

**Principal Risk:**
Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and Disability Services.

**Risk Rating:**

**Risk Appetite:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on identification (May 2017): | 5 | **4** | 20 | **High** |
| Residual Risk (with current controls in place): | 4 | **3** | 12 | **Moderate** |
| Target Risk (after improved controls): | 4 | **2** | 8 | **Low** |
| **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 in each CCG/LA area to ensure that MH and disabilities services are sustainable.<br>2. Leadership of the ICS MH workstream.<br>3. Member of the ICS Health Strategy Group<br>4. Member of North and Central ICP's<br>5. Involvement in DTDT programme for OP and and acute MH Services.<br>6. Member of Gateshead care partnership<br>7. Member of Exec Group for MCP in Sunderland.<br>8. Member of Northumberland Transformation Board<br>9. Member of the Newcastle Joint Exec Group | 1. Successfully influenced service models and across a number of localities.<br>2. Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices.<br>2/3/4/5/6. Updates/monitoring of ICS via Exec/CDT/Board.<br>2. Papers from MH ICS Workstream. | 1. To be the Lead/Prime/Lead Provider for MH and Disabilities across NTW footprint<br>2. Finalise theimplementation plan for STP MH Workstreams<br>3. To deliver the NCM Strategy.<br>4. ICP leadership arrangements to be confirmed |

| | | |
|---|---|---|
| **Ref:** SA3.2 | | |
| **Review Comments: Controls 3, 4, 8 and 9 have been added. Assurance added in relation to control 6 updates also received via Execs/CDT/Board. New action added with regard to ICP Leadership arrangements to be confirmed.** | | |
| **Executive Lead: Chief Executive** | **Board Sub Committee: Board** | **Last Updated/Reviewed: September 2018** |

**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. Agreed contracts in place and process for variations for managing change.<br>2. Locality Partnerships<br>3. New Models of Care for CAMHS Tier 4.<br>4. Business Case and Tender Process<br>5. Achievement of contractual standards. | 1. NTW1617 27 Agreements - Substantial Assurances with no issues of note.<br>1. NTW 1718 22 Commissioning income Monitoring - Substantial Assurance<br>2/3 Quarterly partnership meetings minutes.<br>4. NTW1617 36 Responding to Tenders - Substantial Assurance<br>5. Monitored via Commissioning Report Monthly. | 1. Internal project structure for future Forensic services and specialist childrens services<br>2. Central locality to develop proposals for future or forensic services.<br>3. Seek agreement of Recovery programme with Northumberland CCG.<br>4. Small areas of non compliance with Quality standards being monitored with action in place. |

**Ref:** SA4.1

**Review Comments: No Change to be reviewed quarterly next review due February 2019**

| **Executive Lead: Executive Director of Commissioning and Quality Assurance** | **Board Sub-Committee: RBAC** | **Updated/Review Date: November 2018** |
|---|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

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

| **Corporate Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| That we do not manage our resources effectively through failing to deliver required service change and productivity gains included within the Trust FDP | Risk on Identification | 5 | **3** | 15 | **Moderate** |
| | Residual Risk (with current controls in place): | 5 | **3** | 15 | **Moderate** |
| | Target Risk (after improved controls): | 5 | **2** | 10 | **Low** |
| | **Risk Appetite:** | **Financial/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. Integrated Governance Framework<br>2. Financial Strategy/FDP<br>3. Financial and Operational Policy and proceedure.<br>4. Quality Goals and Quality Account<br>5. Accountability Framework<br>6. Quarterly review of financial delivery.<br>7. Programme agreed for capacity to care and Trust innovation capacity expanded | 1/2/6 Annual Governance statement/ quality account/annual accounts.<br>2. Operational Plan 18/19 agreed by NHSI.<br>3. Policy and PGN.<br>4. External Audit of Quality Account.<br>5. Accountability Framework Reports<br>2. NTW1819 41 Off Payroll Arrangement<br>6. Quartely review of Financial deliver at RBAC<br>3. NTW1718 26 - Payroll Expenditure<br>3. NTW 1718 39 Cashier | 1. Reporting on capacity to care to be implemented through governance structures Apr-19<br>2. Full implementation of activity, capacity, resource and workforce plan to be delivered through operational plan 2019/2020<br>3. Internal Audit review of capacity to care programme to be agreed in internal audit plan by March 2019 |

**Ref: SA4.2**

**Review Comments: No change to residual risk score. Action in relation to capacity to care initiatives has been completed.**
**Actions have been amended following review to update with current situation regarding delivery of activity, capacity, resource and workforce plan through**

| **Executive Lead:** Deputy Chief Executive/Executive Director of Nursing and Chief Operating Officer | **Board Sub Committee: RBAC** | **Updated/Review Date: January 2019** |
|---|---|---|

**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 | **3** | 15 | **Moderate** |
| | Target Risk (after improved controls): | 5 | **1** | 5 | **Very 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.<br>2.Trust Policies and Procedures.<br>3.Compliance with NICE Guidance.<br>4.CQC Compliance Group-review of compliance and Action Plans.<br>5.Performance Review/Integrated Commissioning and Assurance reports.<br>6. Accountability Framework meetings<br>7. Regulatory framework of CQC and NHSI.<br>8. Agreement of Quality Priorities | 1.Independent review of governance 1/3/4/5.Reports/Updates to Board sub Committees.<br>2. Compliance with policies reviewed annually 2/3/4.CQC MHA visits and completed actions<br>3. NTW1718 13 NICE - Good Assurance<br>6. Accountability Framework document<br>7. NTW1718 09 CQC Process Substantial Assurance<br>8. Monitoried via reports/updates | 1. Well led action plans complete however Alnwood actions are ongoing. Review quartely<br>2. Internal Audit 18/19 - please see audit plan<br>3. Clinical Audit 18/19 - Please see audit Plan |

**Ref:** SA5.1

**Review Comments: No Change to be reviewed quarterly next review due February 2019**

| **Executive Lead: Executive Director Commissioning & Quality Assurance** | **Board Sub Committee: Q&P** | **Updated/Review Date: November 2018** |
|---|---|---|

**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 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.<br>2.Trust Policies and Procedures relating to relevant Acts and practice.<br>3.Decision Making Framework.<br>4.Review of CQC MHA Reports and monitoring of Action plans.<br>5.Performance Review/Integrated Performance Report and Action Plans.<br>6. Mental Health Legislation Committee.<br>7. Process for 135/136 legislation with external stakeholders.<br>8. New process in place for monitoring themes arising from MHA Reviewer Visits through MHL Steering Group<br>9. CQC/MHL reviewer session delivered at learning and improvement group in Nov 18 | 1.Independent review of governance<br>2. Compliance with policy/training requirement<br>2. NTW1617 33 MHA Section 17<br>Good level of assurance<br>2. NTW 1718 42 MHA Statutory functions<br>Good level of assurance<br>3. Decision making framework document<br>1/4/5.Reports to Board and sub Committees<br>NTW1718 09 CQC Process Substantial Assurance.<br>6. Minutes of Mental Health Legislation Committee.<br>7. 135/136 action plan complete.<br>8. MHL Steering Group Agenda and Minutes<br>9. Presentation from Learning and Improvement group | 1. IA 1415/NTW/30: MHA Patients Rights Complete management actions identified in limited assurance audit re-audit has taken place awaiting final report and outcomes - March 2019<br>2. Improvement review of MHA Training -77.80%<br>3. Internal Audit 18/19 - Please see audit plan<br>4. Clinical Audit 18/19 - Please see audit plan<br>5. To monitor effectiveness of process for monitoring and reporting on themes from MHA Reviewer Visits - June 2019 |

**Ref:** SA5.2

**Review Comments: Actions complete in relation to establishing a process for monitoring themes from MHA Reviewer visits and presentation to learning and improvement group (in November). A new action has been added to monitor the effectiveness of the process for reporting/reviewing themes from MHA Reviewer Visits.**

| **Executive Lead: Executive Medical Director** | **Board Sub Committee: MHL Group** | **Updated/Review Date: January 2019** |
|---|---|---|

**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.<br>2.Trust Policies and Procedures.<br>3.Reporting and monitoring of complaints, litigation,incidents etc.<br>4.National Reports on Quality and Safety.<br>5.Health and Safety Inspections.<br>6.Trust Programme of Service and PLACE visits.<br>7.CQC Compliance Group.<br>8.Quality Goals and Accounts. | 1. Annual review of Governance Framework.<br>2. Policy Monitoring Framework including Auditable standards, KPI and Annual review.<br>3.Safety Report to Board Sub Committee and Board.<br>3/4/7/9.Performance reports to Q and P<br>5/6/7.Health and Safety,PLACE,service visit and CQC Action Plans.<br>2. NTW1617 32 Risk Management - Substantial Assurance with remedial actions to take<br>8.External Audit of Quality Account.<br>4. NTW1718 05 Continuity Planning | 1. IA NTW/1718/44: Medical Devices Complete management actions identified in reasonable assurance audit<br>2. Outcome and completion of Deciding Together. April 2018<br>3. Internal Audits 2018/2019 - Please see audit plan.<br>4. Clinical Audit 18/19 - please see audit plan<br>5. Delivery of Older Persons Interim Plan. |

**Ref:** SA5.5

**Review Comments: No change this quarter**

| **Executive Lead: Executive Director of Nursing and Chief Operating Officer** | **Board Sub Committee: Q&P** | **Updated/Review Date: January 2019** |
|---|---|---|

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

| **Principal Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. | Risk on identification (April 2018): | **4** | **4** | **16** | **Moderate** |
| | Residual Risk (with current controls in place): | **4** | **3** | **12** | **Moderate** |
| | Target Risk (after improved controls): | **4** | **2** | **8** | **Low** |
| | **Risk Appetite:** | **Quality Effectiveness** | | | **Exceeded** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(Actions to achieve target risk)** |
|---|---|---|
| 1. Workforce Strategy<br>2. RPIW Medical Recruitment<br>3. NTW International recruitment competency process.<br>4. OPEL Framework<br>5. MDT Collegiate Leadership Team in place<br>6. All seven fellowship international recruits arrived into the Trust in December | 1. Delivery of worforce strategy<br>2. RPIW Medical Recruitment outcomes papers<br>3. NTW Recruitment competency documents.<br>4. OPEL Framework Documents.<br>5. MDT leadership advice and support available | 1. Complete international recruitment campaign. Quartely updates.<br>2. Implementation of Medical Induction Programme 2018 - quarterly updates.<br>3. Streamlining of recruitment process. |

**Ref: SA5.9**

**Comments: Additional control added - international recruits arrived in December 2018**

| **Executive Lead: Executive Director of Nursing and Chief Operating Officer** | **Board Sub Committee: Q&P** | **Last Updated/Reviewed: January 2019** |
|---|---|---|

| Internal Audit Plan | | | | | | |
|---|---|---|---|---|---|---|
| Review Area | 2018/19 | | | | | |
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Head of Audit Opinion | | | | • | | |
| Assurance Framework | | | | • | | |
| Leadership, Management and Governance (WELL-LED) | | • | | | | |
| Complaints and claims | | • | | | | |
| Research and Development | | | • | | | |
| Third Party Assurance | | | | • | | |
| Risk Management | | | | • | | |
| IM&T Governance, Controls & Strategy (incl.GDE) | | | • | | SA1.7 | |
| GDPR | • | | | | SA1.7 | |
| Network Continous Testing - Server Operational Management | | • | | • | SA1.7 | |
| Penetration Test | | | • | | SA1.7 | |
| Desktop management: Windows 10 deployment | | • | | | SA1.7 | |
| TAeR System - IT General Controls | | | • | | SA1.7 | |
| IAPTUS System - IT General Controls | | | • | | SA1.7 | |
| UK CRIS Research System | • | | | | SA1.7 | |
| TRAC System - NTW Solutions system | | • | | | SA1.7 | |
| IT Security Incident Management | | | • | | SA1.7 | |
| Information Governance Toolkit | | | | • | SA1.7 | |
| Premises Assurance Model | | • | | | SA5.5 | |
| NHS Improvement Single Oversight Framework - Finance/UoR | | | | • | SA5.5 | |
| Security Management | • | | | | SA5.5 | |
| Patient Experience | | • | | | SA5.1 | |
| Performance Management and Reporting | | • | | | | |
| Quality Account | | | | • | SA1.4 | |
| Waste Management | • | | | | | |
| Fire Safety | • | | | | | |
| Organisational Culture | | | • | | | |

| Review Area | 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Joint Working Arrangements | | | | ● | | |
| Capital Procurement | | | ● | | | |
| Salary Overpayments | | ● | | | SA4.2 | |
| Procurement (Rolling Programme) | | ● | | | SA4.2 | |
| Key Financial Systems | | | ● | | SA4.2 | |
| Cashiering Services | ● | | | | SA4.2 | |
| Patient Monies and belongings | ● | | | | SA4.2 | |
| Non-Pay PAYE | | ● | | | SA4.2 | |
| Losses and Special Payments | | ● | | | SA4.2 | |
| Charitable Funds | ● | | | | SA4.2 | |
| Recruitment and Selection (inc DBS) | | | | ● | SA1.4 | |
| Time and Attendance | | | ● | | | |
| Medical Revalidation | ● | | | | | |
| Medical Job Planning | ● | | | | | |
| Professional Registration | | | | ● | | |
| Occupational Health Service | | ● | | | | |
| Staff Appraisal | | | | ● | | |
| Skills and Training | | | ● | | | |
| Monitoring of Absence | | | | ● | | |
| Local Level Clinical Audit Process | | | | ● | | |
| Mortality Reporting | | | ● | | SA5.1 | |
| Incident Mangement (excl. Serious Incidents) | | ● | | | | |
| Mental Health Act Rolling Programme (patient rights/CTO) | ● | | | ● | SA5.2 | |
| Medical Devices | | | ● | | SA5.5 | |
| Medicine Management | ● | | | | | |
| Medicine Management EPMA | | | | ● | | |
| Health and Safety | | | ● | | | |
| Domestic Homecide | ● | | | | | |

| Clinical Audit Plan | | | | | | |
|---|---|---|---|---|---|---|
| Review Area | 2018/19 | | | | | |
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Clinical Supervision | | | • | | SA5.5 | |
| Nutrition | | | • | | | |
| Seclusion | | • | | | SA5.1 | |
| Care Coordination (North) | | • | | | SA5.1 | |
| Care Coordination (Central) | | | • | | SA5.1 | |
| Care Coordination (South) | | | | • | SA5.1 | |
| Clustering | | | • | | SA5.1 | |
| POMH - UK National Audit: Assessement of the side effects of Depot Antipsychotics and Physical Health Monitoring | | | | • | SA5.1 | |
| Medication Summaries and Discharge Letters | • | | | | SA5.1 | |
| Domestic Homicide Investigation action plan | | • | | | | |
| Mental Health Act Patient Rights | • | | | | SA5.2 | |
| Mental Health Act CTO | | | • | | SA5.2 | |