Sherwood Forest Hospitals Foundation Trust Board Assurance Framework
September 2015

1. **Board Assurance Framework to support delivery of Strategic Priorities**
   The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic priorities/objectives. Assurance may be gained from a wide range of sources, but where possible should be systematic, supported by evidence, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its Assurance committees, through use of Internal Audit and other independent inspection and by systematic collection and scrutiny of performance data to evidence the achievement of the objectives.

2. **Mission**
   To be a clinically and financially sustainable healthcare provider

3. **Vision**
   To champion and deliver the best care, service and welling outcomes possible for each individual in the communities we serve

4. **Values**

   i. **Communicating and working together:**
   - Share information openly and honestly and keep people informed
   - Listen and involve people as partners and equals
   - Work as one team inside our organisation and with other organisations

   ii. **Aspiring and Improving**
   - Set high standards for ourselves and each other
   - Give and receive feedback so everyone can be at their best
   - Keep improving and aspiring for excellence

   iii. **Respectful and Caring:**
   - Treat everyone with courtesy and respect, help people to feel welcome in our organisation
   - Show care and compassion and take time to help
   - Support and value each other and help people to reach their potential

   iv. **Efficient and Safe**
   - Competent and reassuringly professional so we are always safe
   - Reliable and consistent so we are always confident
   - Efficient and timely and respectful off others' time

5. **Strategic Priorities**

SP1	**To consistently deliver safe, effective, high quality care achieving a positive staff and patient experience** Values: Efficient and Safe; Respectful and Caring; Aspiring and Improving
SP2	**To eliminate the variability of access to, and outcomes from our acute and community services** *Values: Aspiring and Improving; Efficient and Safe*
SP3	**To reduce demand on hospital services and deliver care closer to home** Values: Aspiring and Improving; Efficient and Safe; Communicating and Working Together
SP4	**To develop extended clinical networks that benefit the patients we serve** Values: Communicating and Working Together; Aspiring and Improving
SP5	**To provide efficient and cost-effective services and deliver better value healthcare** Values: Efficient and Safe; Aspiring and Improving

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SP1; SP2; SP5	**PRINCIPAL RISK 1: Inability to maintain the quality of patient services demanded**														
	R1.1 Failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand • Failure to ensure there are sufficiently available Medical and Nursing staff to provide safe, timely care in the Emergency Department and Medical wards • Failure to ensure there are sufficient numbers of Radiologists to meet clinical demands • Heavy reliance on Bank, Agency and Locum staff to sustain staffing levels	Executive Director of Nursing and Quality	4	4	16	Workforce Strategy Overseas Recruitment Strategy Nurse Recruitment Strategy Nurse staffing agency and bank data submitted weekly to Executive Management Team Escalation flowchart for managing nursing numbers daily Monitoring of nursing number x 4 a day Recruitment campaigns to attract numbers and quality of staff International recruitment campaign to increase Registered Nurse Numbers Recruitment Strategy for newly qualified nurses 6 monthly acuity and dependency assessment Alternative recruitment strategy for ‘Hard to Fill’ medical posts Providing enhanced care shifts x 4 per shift Focus on reducing LoS >14 days to reduce demands on beds Consultant Radiology staffing Francis team working with the clinical team reviewing radiology provision to identify efficiencies and transformational change	Quality Improvement Plan Staff Survey Report Nursing Staffing Report and UNIFY return Closed winter capacity ward and beds on Stroke Unit £4M case for investment in Registered Nurses approved by Trust Board January 2014 Bed closure plans as part of Transformation programme Francis Group International (FGI) report and recommendation presented to ET Radiology review	** ** *** ** ** ** * *** ***	The Trust is utilising a high number of bank and agency staff to sustain safe nurse staffing levels in Emergency Care & Medicine Struggling to fill all level 4 (reducing harm) requests Consultant radiology workforce Reliance on locum Medical Staff to Meet Emergency Department activity		4	3	12	Reduce the number of and spend on agency and bank staff Implement a nurse staffing investment strategy (3 year plan) to increase the numbers of nurses and change the skill mix to 70:30 (RN:HCA) in line with professional and evidence recommendations Proactive overseas recruitment of Band 5 Nurses to help fill current vacancies: Develop and implement a Consultant Radiology strategy to ensure there are sufficient numbers of Radiologists to meet clinical demands with escalation processes if reporting times are breached Implement alternative, attractive strategies to recruit into ‘hard to fill’ Medical posts Implement alternative models for recruiting and sustaining high calibre front door clinical decision making.	
	R1.2 Failure to embed and sustain quality improvements	Executive Director of Nursing and	4	4	16	Quality Metrics in Ward Assurance Metrics – Monthly meeting chaired by Director of	Annual Health & Safety Report	**	The Trust remains in significant breach for Governance with Monitor	Most Recent CQC assessment judged the Trust as ‘requires	4	3	12	Implementation of the Quality Improvement Plan to support exit from	

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	through: • Failure to meet the Trust's quality strategy goals • Failure to deliver the quality aspects of the contracts with commissioners • Patient experience show a decline in quality • Breach of CQC regulation – currently assessed as 'Requires Improvement' • CIP's impact on safety or unacceptably reduce service quality • The Trust is dependent upon a small group to provide reports, analysis and assurance. • Staff do not receive appropriate and timely feedback from incidents and complaints so actions taken and lessons learnt are not always shared between teams.	Quality				Nursing Safety Thermometer Data Executive/Non Executive Ward visits and observation of care reviews Patient Feedback via complaints, claims, NHS Choice Comments and Family and Friend response Incident reporting CQUIN & Contract Monitoring process Quality and Safety Strategy and Patient Experience and Involvement Strategy Transformation Strategy and programme of work Patient Safety Fellow to support and drive Patient Safety Strategy Whistle Blowing Policy M & M/Clinical Governance meetings at service level Quality meetings between Executives and CCG Quality leads Appraisal and revalidation C Difficile, falls and Pressure Ulcer Reduction plans Trust Board Committee Structure to oversee the different components of reporting QIA process intrinsic within CIP process Risk Management Strategy Being Open Policy and Duty of Candor	6 monthly nursing skill mix review Patient Story to Trust Board Elements of CQC Inspection Report and Quality Summit – July 2014 Quality Improvement Plan overseen by the Trust Board Inpatient and staff surveys – action plans GMC Trainee survey (patient survey) Elements of HEMM report – Action plans National clinical Audits Complaints Annual Report Infection Control Annual Report Safeguarding Annual Report Risk Registers	** *** *** ** *** *** *** *** ** ** ** *	Staff feel they are not receiving appropriate and timely feedback	improvement'.				Special Measures Implement quality summit and Mock CQC visit to improve learning & sharing Develop and implement a Sharing and Learning strategy with evidence of individual learning	
	R1.3 Implementation of Medway PAS impacting on quality of care and patient experience	Executive Medical Director	5	4	20	PAS project board meet monthly – risks are reviewed, escalated where appropriate and mitigated where possible. and reported if necessary to monthly Risk Committee meeting Information Team running regular report to check data accuracy: • Data Quality reports are run on patients with double stops and double starts	Regular reports toe Executive Team, Trust Management Board and Board of Directors. Internal audit report on PAS fitness for purpose highlighted that compliance with mandatory reporting requirements is	* **	Financial with extra resources and no clear time limit Clinical with outpatient issues – addressed through Principal risk 4.5		5	3	15	Review next PAS release and patch updates Outpatient programme board	

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						• Daily reports that cover areas like un-reconciled Outpatient Appointments and Missing Outpatient Outcomes are circulated to operational teams and divisions (see principal risk 4.5 – Failure to manage and co ordinate outpatient services within clinical and national standards • CAS files are run daily	satisfactory								
SP2;SP4	**PRINCIPAL RISK 2: Essential components of round the clock (24/7) urgent/emergency care not in place/not effective**														
	R2.1 Failure to meet national standard of care/inappropriate use of resources/poor quality junior training and education Potential Effects: poor quality care, failure to control costs and loss of training grade posts Potential impact: Loss of reputation, collapse of services and restriction of license	Executive Medical Director	5	4	20	Appraisal, revalidation and job planning for senior medical workforce Workforce Strategy Medical Director has regular meetings with Junior doctors – see principal risk 5.5 Stafflo locum usage report Variable pay tracking	Training and Education reports to OD and Workforce Ctte External support for Radiology (Francis) reporting through Transformation Board Foundation and GP Trainee Survey Post induction and exit meetings with Junior Doctors Junior Doctor forums GMC Surveys HEEM surveys and visits – elements of Quarterly report from DME incudes update on trainee issues both internal and external focus E Midlands Acute Chief Execs group and ATOS external gap analysis QUIPP for 7 day	** *** *** ** ** *** *** *** ***	7 day services project status – national standard of care Increase visibility of trainee feedback to a wider audience – see detailed actions in principal risk 5.5 Quality information to assess clinical productivity Continued high spending on locum staff	Overnight Junior Doctor Cover Urology Cover at weekends and ongoing T & O Concerns	5	3	15	Ascertain status of 7 day services nationally Implement software option to enhance quality information with regard to clinical productivity Locum staff costs to be reduced Additional F2 on H@N team Enhance Urology cover at weekends Monthly meetings with T & O team to review progress .	

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							standard targets for 2015 onwards								
	R2.2 Failure to deliver appropriate flow and reduce LoS/Failure to reduce gap in weekend and weekday mortality Potential effects: Poor quality patient experience, poor quality care, failure to meet performance targets and failure to meet financial milestones Potential impact: Loss of reputation and license to practice	Executive Medical Director	5	4	20	Workforce Strategy Divisional Performance meetings Divisional governance meetings Trusts Mortality Group chaired by Senior clinician Weekly capacity and flow meetings Better Together Urgent and Proactive Care Steering Group Transformation Board and Steering Group	Flow and 7 Day services programme reports HSMR alerts ATOS Gap Analysis and E Mids Chief Execs Meeting Better Together Board System Resilience Group Dr Foster Reports	** *** *** *** *** ***	Mortality not identified as a separate risk on BAF document with regard to Sepsis concerns		5	3	15	Review weekend mortality rates Mortality action plan includes focus on sepsis	
	R2.3 Increased serious incidents, compromised patient safety Potential effects: Poor patient experience, poor quality care, adverse publicity and poor staff morale Potential Impact: Loss of reputation and license to practice	Executive Medical Director	5	4	20	Executive/Non Executive Ward visits and observation of care reviews Patient Feedback via complaints, claims, NHS Choice Comments and Family and Friend responses SI investigation process Quality and Safety Strategy and Patient Experience and Involvement Strategy Transformation Strategy and programme of work Quality Improvement Plan overseen by the Trust Board Patient Safety Fellow to support and drive Patient Safety Strategy 'Raising Concerns' Whistle blowing policy M & M/Clinical Governance meetings at service level Quality meetings between Executives and CCG Quality leads Appraisal and revalidation C Difficile, falls and Pressure Ulcer Reduction plans Trust Board Committee Structure and process of escalation Risk Management Strategy	Audit Committee Report to the Board Inpatient and Staff surveys PROM's National Clinical Audits Risk Register Patient Story to Trust Board Complaints Annual Report Infection Control Annual Report Safeguarding Annual Report	** *** *** ** *** ** ** **	Preparation for and learning from – Inquests	Improved system and evidence of organisational learning	5	3	15	Streamlined process for preparation for inquests Ensure learning from inquests Ensure organisational learning through improve opportunities to share learning	

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	R2.4 Ensure ED is fit for future purpose.	Executive Medical Director	5	4	20	Workforce strategy International recruitment programme for medical staff including Deanery Full recruitment to Cardiology consultant workforce External support for Radiology transformation programme Development of enhanced training programmes for ED junior doctors	7 day services gap analysis identified key areas to progress Transformation Board and Steering group reporting on flow programme System Resilience Group Urgent and proactive care programme reports to Better Together Board	*** ** *** **		Retention of Consultants in current environment is difficult	5	4	20	Develop an ED Workforce Strategy Risk assessment and mitigation plan for loss of ED consultants shared with CCG and wider health economy partners Overseas recruitment (see principal risk 5.4) Attract more trainees (see principal risk 5.4)	
	R2.5 Single handed services become non-viable	Executive Medical Director	5	4	20	Memorandum of Understanding with other local health providers Orthodontic service terminated On-going dialogue with other health providers about providing a comprehensive Breast service which would include enhanced medical cover Cancer Strategy	On-going dialogue with Better Together and CCG re Mid Notts Cancer Strategy and enhanced Nottinghamshire Pathways Cancer Management Board reports to TMB	*** *	Service supported by more than 1 partner		5	3	15	Review of Clinical Services as part of clinical strategy development.	
	R2.6 On call arrangements for Radiology, Ophthalmology, Microbiology, Urology, Vascular and Stroke become non tenable	Executive Medical Director	5	4	20	Enhanced outsourcing and locum cover in Radiology Stroke service option appraisal planned with NUG and CCG partners. Service monitored via Nottinghamshire Stroke Partnership Board. Vascular service upgraded to include weekly publishing of cover rota for clinics, ward and on call. On-going issues with job planning and scope of services on-going via VLIT Board. Microbiology arrangements under discussion via Western Alliance and Empath. Third consultant appointment planned Urology on call arrangements clarified with Division. External Recommendations Policy	Planning and delivery of Radiology and 7 Day Service Programmes reported via Transformation Board Feedback from external visits – HEEM, GMC, reported to OD and Workforce and Trust Board Vascular and Stroke Nottinghamshire partnership Board report to CCG	** *** ***	Monitoring of on call arrangements Clear lines for reporting for external reports		5	4	20	Ensure services are monitored robustly with regard to on-call arrangements	

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SP1, SP5	**PRINCIPAL RISK 3: Failure to deliver and maintain financial sustainability**														
	R3.1 Failing to find a solution to the PFI excess burden	Chief Financial Officer	5	4	20	Relationship with Monitor Working cash facility (WCF) agreed with Monitor for 2015/16	Ernst & Young report on the value of the PFI Potential support from the PFU (Private Finance Unit) to identify possible courses of action Monitor Licence recognises the need to isolate the PFI impact from underlying financial performance Monitor are aware that a longer-term solution for the Trust excess PFI costs is required Monitor have raised have raised this issue as part of the Mid-Notts Review and engagement with CCGs regarding the level of local health community contribution Improvement plan submitted – routine monitoring and updates provided to Monitor	*** *** *** *** **	Monitor has told the Trust that no PFI funding assumption should be built into the Annual Plan The Trust is required to demonstrate a high level of performance and financial improvement as a pre-requisite to agreeing on-going external support	Formal commitment to liquidity support for future financial years will need to be applied for annually Off track with CIP – liquidity support needs to be aligned with the Trust demonstrating delivery of CIPs	5	4	20	On-going updates to Monitor and discussions with the CCGs Evidence of improved financial performance and agreement with local health community on the level of recurrent support Additional cash support requirement to be discussed with Monitor Funds are being drawn down on a monthly basis and future formal commitments to be sought beyond 2015/16	
	R3.2 Insufficient cash liquidity	Chief Financial Officer	5	4	20	Cash management – daily monitoring of cash balances, restrictions on payments as required. Cost control – routine monthly meetings with Finance and divisional staff in place to monitor and challenge actual and forecast outturn Review and reduction in financial authority levels Turnaround Board and c. 13 workstreams established to contribute to Turnaround – weekly meetings (initial focus on variable pay with detailed challenge on a weekly basis Cashflow forecast monitoring informs the management of payments/debts as	Support requirements of the value of the approved financial deficit submitted for 2015/16 – evidence through reporting to: • Board of Directors • Finance Committee • Monitor Monitor Licence recognises the negative impact of the PFI impact on the underlying financial performance	*** *** ***	Relationship of Service Lines to divisional performance needs to be strengthened as identified in the Baker Tilly report WCF/revenue loan in place for period ending 11th October 2015 – to be finalised for remainder of year Effectiveness of Divisional and Corporate cost control Improvement plan not yet submitted to Monitor	Formal commitment to WCF/loans for future financial years will need to be applied for annually Population of CIP delivery tracker – liquidity support needs to be aligned with the Trust demonstrating delivery of CIPs Baker Tilly report identified areas for improvement Fully understanding effects of new loan / working capital regime	5	4	20	Loans/WCF agreement to be reached with Monitor Effectiveness of cost control Strengthen CIP development and monitoring processes, including CIP pipeline and delivery tracker Baker Tilly commissioned to carry out cost control and financial governance review On-going development of performance management arrangements at Service Line Level Discussion with Monitor to provide	

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						ncecessar	Going Concern report accepted by external auditors and updates to each Audit & Assurance Committee meeting KPMG Governance Review – agreed at February 2014 Board of Directors meeting that all actions had been completed, including cash management actions Internal audit reports – Significant Assurance provided on Cash Management, Pay Expenditure, Key Financial Systems and Budgetary Control reports	*** *** ***		and associated risks, including lack of definition of 'additional terms' and Monitor approval process/requirements.				assurance that the plan accounts for the key risks and evidences sufficient improvement Phase 1 short-term plan Phase 2 – long-term plan Funds are being drawn down on a monthly basis and future formal commitments to be sought for the remainder of 2015/16 and future years Effects of new loan/working capital regime and Monitor approval process/requirements to be fully understood by Trust officers as required.	
	R3.3 Failure to accurately determine, agree and achieve the financial plan	Chief Financial Officer	5	4	20	PMO Director appointed to strengthen CIP development and monitoring processes, including CIP pipeline Appointment of PwC to review 2015/16 plan and provide assurance on underlying deficit to inform the revised turnaround plan to be submitted in Q3 Potential recruitment of external profession support to produce formal turnaround plan for submission to Monitor in Q3 Turnaround Board and c.13 workstreams established to contribute to Turnaround – weekly meetings (initial focus on variable pay with detailed challenge on a weekly basis) Actively engaging with commissioners and other partners to deliver the 'Better Together' and Better Care Fund agendas through the Mid Notts. Joint working group Management of vacancies and locum/agency/bank staff usage	Delviery Engine resource in place Monthly performance monitoring meetings with divisions CCG/NHS England 2015/16 contrat agreed with CCG on a PbR basis New nurse/admin bank process in place Independent review of the Annual Plan undertaken in November 2014 External support appointed to conduct a review of 2015/16 plan and underlying financial position Benefits realisation of	* ** ** *** ***	Impact of 'Better Together' QIPP on 2014/15 contract impacts on ability of Trust to strip out associated costs where there is a reduction in demand and income. Expenditure on certain categories remains above target – e.g. agency/variable pay Turnaround plan in development	Acceptance by Monitor that the plan accounts for the key risks and evidences sufficient improvement in years 2-5 Mitigation of performance risks to plan Requirement for reinforcing ownership of Service Lines, divisional and Trust level CIP Schemes of required value not yet identified for 2015/16 Further work required to develop CIP pipeline over next 3-5 years	5	4	20	Trusts divisional managers and corporate support are fully engaged with joint meeting of CCG, SFH and CHP PMO's where the delivery and planning of QIPP and their impact at the respective organisations is closely monitored to help inform internal actions Procurement Category Manager concentrating on reduction of agency spend Focus clearly in 2015/16 to deliver an improvement on current planned forecast deficit of £44.5m and associated loan requirements Turnaround plan in development Discussions with Monitor to provide assurance that the plan accounts for the key risks evidences sufficient improvement Phase 1 – short term plan	

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						Daily bed meetings to establish staffing requirements and minimise the use of ad-hoc staff	clinically led transformation programme, monitored through PMO External review on the effectiveness of Trust cost control measures commissioned – action plan agreed and submitted to A &AC November 2014 and progress monitored through Finance Committee Patient level coting implementation project team recruited – Trust identified as Roadmap Partner' within Monitor's 'Improving the costing of NHS services' proposal – funding received within the 2014/15 Transformation Funding from the CCG			Baker Tilly report identified areas for improvement On-going recruitment to Trust establishment (nursing)				Phase 2 – long term plan Clear triangulation and mapping of 2015/16 contract risks to divisions and Service Line for mitigating actions during 2014/15 Weekly Turnaround Board meetins in place to identify 2015/16 and future opportunities Recruitment drive for substantive and bank staff Implement recommendations /identified areas for improvement from Baker Tilly review.	
SP3, SP4, SP5	**PRINCIPLE RISK 4: Unable to deliver and maintain clinical sustainability**														
	R4.1 Whole system fails to reduce demand on acute services resulting in inability to reduce footprint & cost base	Director of Operations	4	4	16	Streaming to PC24 on the Kings Mill Site Frail/elderly team at the front door of Kings Mill Site Complex discharge Team and Multidisciplinary Discharge hub – and the associated discharge to assess service Clinical decision unit at the Kings Mill site – increased use of ambulatory pathways to prevent inpatient admission Flow Matron and Emergency Flow Co-ordinators Emergency Care Improvement Lead and supporting team	Data in relation to number of patients streamed and 48% increase in number of patients using PC24 in last year Data regarding reduction in long length of stay patients >14 day reduced by 1000 deddays (12%) and >20 day more than 1100 beddays (15%) Correlation between increased attendance and admissions Commissioned Beds in use (Ward 21, Ward 33 no longer in use at Kings Mill	*** ***	Consistency in use of alternatives to admission by high use of locum medical staff Usage of Discharge to Assess Service limitations by organisations other than SFHFT		3	3	9	Reduce reliance on locum medical staff Improve control of Discharge to Assess service through greater oversight at Urgent Care Working Group and the Systems Resilience Group	

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	R4.2 Failure to reduce Length of Stay year on year	Director of Operations	4	4	16	Increased ambulatory care pathways via clinical decisions and medical day case unit Co-location of discharge team with social services to streamline assessment processes All patients have an expected date of discharge EDD Daily review of long LoS>14 day patients at Discharge Meeting Emergency flow transformation programme Provision of an economy wide pull team to ensure patients are appropriately and safely transported to other facilities Establishment of Transfer to Assess bed aligned to PRISM model	Hospital) ECIST Review in December 2013 and followed up again in May 2014 recommended the focus on long length of stay patients who do not require acute care System Resilience Group plan and bi-weekly monitoring of progress and planning assumptions Urgent Care Working Group and the reviews of planning assumptions Data evidence of clinical decision unit utilisation Emergency Flow Programme updates providing live status of the programme, as part of Transformation Emergency flow dashboard Daily list of patients >14 days Length of Stay Throughput of discharge lounge Silver report analysis Divisional Performance reviews Weekly capacity meeting involving all head of service and Matrons to review KPIs and hold to account Independent report by CCG in December 2014 and January 2015	* ** * * * * * * ***			3	3	9		

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The delivery of which priorities are affected by the risk?	What could prevent the objective from being achieved?	Individual ultimately accountable for managing the risk and achieving the priority/objective	Rating of 1 to 5	Rating of 1 to 5	A x B	What existing key controls and processes are in place to secure delivery of the objective by mitigating risk?	What **positive** assurances are there that the controls are effective? (L1 – Internal, staff/management; L2 – Committee/Peers; L2 External (IA,EA,3rd party)	*= level 1 **= level 2 *** = level 3	Are there any gaps in the effectiveness of controls to secure delivery of objectives?	Where is there a lack of evidence the control is effective?	Rating of 1 to 5	Rating of 1 to 5	IxL	What action is necessary to address the gap including indicative timescales?	Same , better / worse
							Perfect week held with key impacts – improved relationships between providers and the start of integration of teams System Resilience Group Scrutiny Urgent Care Work Group Scrutiny	** *** ***							
	R4.3 Failure to reduce avoidable admissions	Director of Operations	4	4	16	Streaming to PC 24 on the Kings Mill Site Frail/elderly team at the front door of Kings Mill Site Hot phones for high risk specialties, cardiology, respiratory & gastroenterology Hot clinics for high risk specialties, cardiology, respiratory & gastroenterology Clinical decisions unit at the Kings Mill Site – increase use of ambulatory pathways to prevent inpatient admissions for some conditions Acute Physicians working in ED increasing discharge directly from ED and controlling readmissions	Data in relation to number of patients streamed and 48% increase in number of patients using PC24 2014/15 Data regarding avoided admissions from internal services in place Correlation between increased attendances and admissions Divisional performance reviews Independent report by CCG in December 2014 System Resilience Group scrutiny Joint PMO with CCG on QIPP schemes (which include the review of readmissions)	* * * * *** *** ***	Consistency in use of alternatives to admission by high use of locum medical staff utilisation of hot clinic/phone arrangements		3	3	9	Reduced reliance on locum medical staff Acute Physician permanently rostered to work in ED to relieve Medical take pressure and improve decision making (reduce readmissions) Increase oversight and monitor usage of hot phone and hot clinics	
	R4.4 Failure to achieve productivity and efficiency aims	Director of Operations	4	4	16	Outpatient Improvement Board (OPIB) Elective transformation programme Job planning processes Emergency transformation programme and specifically Length of Stay > 14 days project Variable pay workstream Turnaround Board/Turnaround Team	OPIB Dashboard – utilisation improvement, reconciliation, DNA etc. and highlight reports through to RMC/Quality committees Emergency Flow Dashboard and Programme Updates Job planning	* * *	Pace of delivery of the programme against plans Pace and engagement on enabling job plan changes and implement the Allocate System	Variable Pay and the lack of delivery against flow (LoS) Improvements (ward closures)	3	3	9	Focus Turnaround Board Oversight on Variable pay and extend project programme resource working on it Written communication of job plan changes instead of verbal consultation to agree changes	

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							documentation and the Allocate Planning System								
							Division Performance reviews	*							
							Workstream report to Turnaround Board	**							
							IMAS reports on RTT and Emergency Care	***							
							OPID feedback from Improvement Director and CCGs	***							
							System Resilience Group Scrutiny	***							
							Turnaround Team Review of Schemes	**							
								***							
	R4.5 Failure to manage and coordinate outpatient services within clinical and national standards.	Director of Operations	4	4	16	Improved reporting systems (weekly/daily/twice daily) to inform teams and subsequent management action to identify potential escalation and to deliver risk mitigation Weekly review of progress (RTT meetings) and actions Daily Outpatient and Administrate services capacity review meeting in place chaired by Deputy COO/DGM's Fortnightly review meetings with CCG in place Fortnightly outpatient improvement board Project manager in place for three key work streams within the Outpatient Improvement Programme	RTT reporting and progress against trajectory	*			4	4	16		
							Outpatient Improvement Dashboard	*							
							Daily Outpatient Capacity Dashboard and Action lists	*							
							Business Case for increase in administration and informatics staffing levels	*							
							Use of IST – Modelling demand and capacity Tools	*							
							Monthly reports to Divisional Performance, RMC, CQ&GC then to Quality Committee	*							
							18 week intensive support team IMAS support in developing sign off of improvement plan July 2015	***							
							Governor, Patient, CCG and staff	**							

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							representation on OPIB Improvement Director Review of Improvement Plans Weekly CCG Performance Management Meetings	 ** ***							
	R4.6 Failure to achieve JAG accreditation	Director of Operations	3	3	9	Additional administration staff shortlisted to support booking and audit data collection Band 6 deputy department leader appointed – in post Tracking and tracing audit completed Ventilation installation completed Endobase system in use which will provide data required to comply with BSG KPI's User group meetings =established – forum for presentation and discussion of BSG KPI's Staff Survey completed – action plan to follow Acute Gastroenterologist of the day is now responsible for vetting referrals Audit of Histopathology results review completed Capacity flexed to address waiting times including urgent cancers, routine diagnostics and surveillance patients. NHSI capacity and demand model completed	Achievement of regional training centre status Weekly performance management of patient waiting times Twice yearly GRS submission aligned with JAG	*** * ***	JAG Accreditation status currently: Assessed – Improvement required – deferred for 6 months BSG KPI reporting system to be developed using Endobase and Medway data, including 30 day M&M Staff to be signed off against the endoscopy competences – newly appointed deputy department leader to lead		2	2	4	Action plan developed and tracked operationally Audit tool to be developed Staff to be signed off against endoscopy competences	
SP1, SP2, SP4, SP5	**PRINCIPLE RISK 5: Failure to sustain an engaged and effective workforce**														
	R5.1a Failure to recruit, retain and develop competent leaders	Executive Director of HR	4	4	16	Effective and robust recruitment campaigns to attract individuals of the right calibre Proactive media campaigns – highlighting the successes of the Trust Leadership and Management Development Programmes – general staff, nursing and medical	Exit Interview data – highlight future work priorities to aid retention Internal Audit of recruitment processes – full review October 2013 and follow up May 2014 – Significant assurance for Recruitment and	** **	1.0 Robust system for talent management and succession planning 2.0 Development and implementation of leaders to operate effectively in a service line management model. 3.0 Gap analysis and development of 'middle tier' managers 4.0 Lack of comprehensive Leadership Strategy		4	3	12	1.1 Develop and implement talent management and succession planning process 2.1 Develop and implement service line management development programme 3.1 Utilise data from TNA and focus groups to develop training interventions to enhance effectiveness of middle managers	

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						Board Development Programme Executive Team – individual and team coaching Effective personal development and new system (appraisal) Recruitment and Selection Policy and procedure TED Strategy Workforce Strategy Organisational Development Strategy Leadership Strategy Training Needs Analysis	Retention and limited assurance for process TED Annual Report Regular feedback is received regarding the effectiveness of our leadership and management development offering, this together with the annual plan are used to review the programmes delivered and ensure they remain fit for purpose Annual staff and quarterly Pulse surveys Internal audit of Return to Work interviews – completed July/Aug 2014 – reported to Board of Director in September 2014.	 ** ** *** ** ***						4.0 Development of Trust-wide leadership strategy	
	R5.2 Low levels of staff satisfaction , health and wellbeing	Executive Director of HR	4	4	16	Sickness Absence policy and procedure Action plans submitted resulting from 'Team Conversations' Sickness Absence rates and reasons for absence Health and Well-being group – subcommittee of OD and Workforce Committee Occupational Health Services Enhanced support mechanism for staff who are absent with stress related illness	National NHS Staff Survey results – associated action plans Annual NHS Staff Survey Outcomes and associated action plan Outputs of quarterly staff survey and staff FFT results Benchmark data assessed for Annual NHS Staff Survey and Staff FFT Annual Occupational Health Report – identifying attendances and Trends Benchmark sickness absence data reported to Board of Directors	*** ** ** ** *** **	1.0 Lack of evidence that Quality for All has been embedded across the Trust 2.0 Absence s related to stress remains high		4	3	12	Extensive communications campaign to further engage managers in leading the implementation of Quality for All across the Trust Develop and implement mechanism for individual stress risk assessment – ensure appropriate support plans are developed	

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	R5.3 Low levels of participation in training and appraisal	Executive Director of HR	4	4	16	Appraisal Policy & Procedure Mandatory Training Policy TED Strategy Annual completion of Training Needs Analysis and review of training programmes Employee Self-service launched to allow employees to access training records on line	Internal Audit review of Mandatory Training survey – Benchmarking report December 2013ce TED Annual Report and Strategy presented to TMB	** **		Appraisal rates remain below the 98% target Mandatory training compliance remains below the 90% target	4	3	12	Provide on-going mandatory training to incorporate new legislations Enhance reporting of appraisal data	
	R5.4 Failure to recruit and retain an appropriately qualified workforce	Executive Director of HR	4	4	16	Monitoring of staff in post numbers by staff group Monitoring of pay expenditure by staff group Monitoring of nursing staff numbers and rotas Staff Group specific recruitment campaigns, Local, National & International e.g Registered Nurses Recruitment and Retention Policy Medical Workforce Strategy Daily staffing report to executive team to monitor Registered Nurses staffing numbers	Recruitment of international nurses has been successful with high levels of retention The Trust has recruited 140 Registered nurses, 56 of which were international. Subsequently on 4 international nurses have left the Trust this is a higher retention level that other local trusts	***	1.0 Staff in post numbers remain below acceptable levels		4	3	12	International recruitment campaigns – Northern Ireland, Greece and Rome Local and International Recruitment Campaigns Enhance local media campaigns	
	R5.5 Failure to ensure high quality of safe training and education provision	Director of HR	4	4	16	Health Education England Quality Standard Workforce and OD Committee scrutiny Training, Education and Development Committee scrutiny TED Strategy Workforce Strategy Organisational Development Strategy Undergraduate and Post Graduate Medical Education Committees Pre-Registration nursing Practice Learning Committee Training, Education and Development Committee Drop in sessions for junior doctors with Medical Director and Post Graduate Medical Education Directors.	Annual Health Education England Quality Visit of multi-professional training and education Annual GMC survey Director of Post Graduate Medical Education quarterly report to the Board Foundation trainees end of placement surveys TED Annual Report HEI Quality visits and outcomes Annual Health Education East Midlands annual quality review	*** *** ** ** ** *** ***	1.0 Our ability to engage with trainees informally to identify potential patient safety/educational issues early 2.0 Our ability to engage with service in order to provide assurance that trainees are well supported and service provision is effective.		4	3	12	1.1 To develop informal sensing approaches with student nurses and AHP trainees to sense check the quality of their training and education. 1.2 Medical Director to lead T&O team development sessions to help improve communication, behavioural standards and surgery site markings and consent process This is a significant risk for the Trust as HEEM have made it clear that T&O trainees could be removed from the Trust in August 2015 if sustained improvement are not implemented 1.3 Current Junior Doctors Forums are not working and allowing the Trust to pick up on issues from trainees regarding concerns with training, patient safety and operational issues..	

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							NMC Quality reviews of education provision	***						2.1 Development of the Radiology Team to improve communications and behaviours: 2.2 Improvement of variability of locum cover and senior support in ED 2.3 Improvement in the recording of blood results on the ICE system 2.4 Improvements required in the way Ophthalmology clinics are run and staffed. 2.5 Improved supervision of trainee doctors are required to ensure adequate supervision is in place at all times or trainees will be removed from the Trust in August 2015 2.6 ED workforce plan is not sustainable and requires further improvement in order to a maintain sustainability 2.7 Greater assurance is required from service to ensure that known issues with service provision that may affect trainees or educational visits are identified prior to an education visit and action plans are in place to address these GMC Enhance monitoring of ED	

Risk Rating Matrix (Risk Management Policy- Nov 2014)

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25