Sherwood Forest Hospitals Foundation Trust Board Assurance Framework
APRIL 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 3 a day All nursing staffing information collated into one spread sheet (includes investment, actual, planned, and vacancies). Additional Night Registered Nurse on all inpatient wards since July 2013 Surgical wards have moved to the second phase of the Keogh investment (60:40 skill mix and 3+1 on night duty). 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 Utilising alternative roles to enhance care e.g. PDM posts Francis team working with the clinical team reviewing radiology provision to identify efficiencies and transformational change Alternative recruitment strategy for ‘Hard to Fill’ medical posts	Quality Improvement Plan Bed closure plans as part of Transformation programme 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 >50 Overseas RGN’s in post Practice Development Nurse appointed to lead on international recruitment and provide orientation support 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 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	
	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	**	Most Recent CQC assessment judged the Trust as ‘requires improvement’.		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 Practice Development Matrons recruited and working across the Trust to drive Quality Improvements 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 Established Risk Committee	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 Monthly Nurse Staffing levels and UNIFY return 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	** *** *** ** ** *** *** *** ** ** **	Staff feel they are not receiving appropriate and timely feedback					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 fortnightly – risks are reviewed, escalated where appropriate and mitigated where possible. Data Quality is a standing item on the Data Quality Group which report to the Data Quality Committee Information Team running regular report to check data accuracy: • Data Quality reports are run on	Regular reports toe Executive Team, Trust Management Board and Board of Directors.	*	Post implementation risks • Clinical with outpatient issues • Reputation with data validity and RTT reporting • Financial with extra resources and no clear time limit	Data Quality issues – RTT, Review Lists	5	3	15	Post implementation review commissioned • Final report expected February 2015 Hot fix which should solve 2 of the 3 RTT issues expected to be live in 4-5 weeks Provisional legal advice received; fin al report expected with tactical	

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						patients with double stops and double starts • Daily reports that cover areas like un-reconciled Outpatient Appointments and Missing Outpatient Outcomes are circulated to operational teams and divisions • CAS files are run daily								recommendations and risk assessment of full legal action Reassessment of risk particularly in OP Clarity on benefits tracking Agreed way forward to dissect the financial delivery	
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 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 HEE surveys and visits 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 standard targets for 2015 onwards	** *** *** ** ** *** *** *** *** ****	No direct data collection related to 7 day services standards. Discussion at Medical Managers to create a Clinical Productivity group and create ‘Medical Metrics’ Increase visibility of trainee feedback to a wider audience		5	3	15	24/7 Steering group to develop Medical metrics Create further opportunities for Junior Doctors to interact with Medical Director	

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	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	** *** *** *** *** ***	Improved visibility of Better Together delivery within the trust		5	3	15	Regular briefing and reporting to Exec Team, TMB and Board of Directors	
	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	** *** *** ** *** ** ** **	Improved system and evidence of organisational learning		5	3	15	Implementation of the Quality Improvement Plan	
	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	7 day services gap analysis identified key areas to progress	***	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	

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						Full recruitment to Cardiology consultant workforce External support for Radiology transformation programme Development of enhanced training programmes for ED junior doctors	Transformation Board and Steering group reporting on flow programme System Resilience Group Urgent and proactive care programme reports to Better Together Board	** *** **	Distribution of training grade doctors will be based on quality of training which in turn depends on adequate medical staffing					CCG and wider health economy partners	
	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	On-going dialogue with Better Together and CCG re Mid Notts Cancer Strategy and enhanced Nottinghamshire Pathways	***	Lack of SFH Cancer Strategy		5	3	15	Develop Cancer Strategy Cancer Strategy to be submitted to divisional board for approval and to ensure alignment with annual plans.	
	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 On-going dialogue with other local health providers and EMRAD to further recruitment Notice served on local health providers to withdraw out of hours Ophthalmology cover but extended hours service in situ 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. On-going dialogue with local health providers to develop shared services and strengthen cancer pathways	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	** *** ***	Clear lines for reporting for external reports		5	4	20	External Recommendations Policy implemented – further work to ensure embedded	

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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	PDC/WCF loans in place for 2015/16 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 Restrictions on discretionary spend agreed at Trust level	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 Effectiveness of Divisional and Corporate cost control	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 Baker Tilly report identified areas for improvement Fully understanding effects of new loan / working capital regime	5	4	20	Funds are being drawn down on a monthly basis and future formal commitments sought Weekly CIP performance meetings in place to address shortfall– chaired by the Head of PMO Baker Tilly commissioned to carry out cost control and financial governance review Ongoing development of performance management arrangements at Service Line Level	

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							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 Internal audit reports – Significant Assurance provided on Cash Management, Pay Expenditure, Key Financial Systems and Budgetary Control reports Monthly report to Board of Directors, sub committees and Executive Team /TMB outlining cash position and forecast cash flows	*** *** *** ***		and associated risks, including lack of definition of 'additional terms' and Monitor approval process/requirements.				New Management Accounts staff members to have full inductions and specific training to become familiar with the role as soon as possible. Review of Financial Governance to be undertaken at Monitor's request. 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	Agreement of financial plan for 2015/16 Performance management of the plan Management of vacancies and locum/agency /bank staff usage Quality assessed CIP Programme Actively engaging with commissioners and other partners to deliver the 'Better Together' and Better Care Fund agendas through the Mid Notts. joint working group Monthly divisional performance management meetings in place with full executive engagement Daily bed meeting to establish staffing requirement and minimise the use of ad-hoc staff	PbR base contract Monthly performance monitoring meetings with divisions and CCG 2014-15 contract agreed with CCG on PbR basis with performance risks mitigated as part of contract settlement Independent review of the Annual Plan undertaken in November 2014 Patient level costing implementation project team to be recruited – Trust identified as 'Roadmap Partner' within Monitor's	*** *** *** *** ***	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. New risk to 2015/16 contract settlement – potential for reduced funding from commissioners Expenditure on certain categories remains above target – e.g. agency/variable pay 2015/16 plan and budget not yet agreed 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 On-going engagement commissioners to optimise 2015/16 contract settlement Procurement Category Manager concentrating on reduction of agency spend Review of budget pressures and mitigations Turnaround plan in development Discussions with Monitor to provide assurance that the plan accounts for the key risks evidences sufficient improvement in years 2-5	

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							‘Improving the costing of NHS services’ proposal – funding received within the 2014/15 Transformation Funding from the CCG Benefits realisation of clinically led transformation programme, monitored through PMO	**		Delivery Engine not yet fully resourced Baker Tilly report identified areas for improvement Under capacity in key finance areas, specifically in the FPM area, presents a risk to delivery. Mitigation includes the agreement to appoint a deputy CFO that will have oversight of performance and delivery from a Finance point of view, and continuing to source a permanent FPM for the current vacancy Independent assurance that the controls in place are minimising excess staff costs On-going recruitment to Trust establishment (nursing)				Clear triangulation and mapping of 2015/16 contract risks to divisions and Service Line for mitigating actions during 2014/15 Appoint a deputy CFO that will have oversight of performance and delivery form a Finance point of view, and continue to source a permanent FPM for the current vacancy Weekly CIP Performance meetings in place to address shortfall in 2014/15 and to identify 2015/16 opportunities chaired by the Head of PMO Recruitment drive for substantive and bank staff Strengthening of Financial resource to the Transformation Team – lead F &PM to be identified	
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 Hot phones for high risk specialties, cardiology, respiratory & gastroenterology Clinical decision unit at the Kings Mill site – increased use of ambulatory pathways to prevent inpatient admission	ECIST review in December 2013 and followed up in May 2014 System Resilience Group plan and weekly monitoring	*** ***	Consistency in use of alternatives to admission by high use of locum medical staff Poor utilisation of hot clinic/phone arrangements		3	3	9	Reduce reliance on locum medical staff	
	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 Jonah live system – 7 day review of	Data review of Jonah live – nos of patients with EDDs and monitor improvement to reduce delays Emergency Flow Programme updats providing live status of the programme, as part of	** **	Difficulty to measure the impact of co-locating services		3	3	9	Impact of co-location of services - Agree KPI’s between services	

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						patients past EDD 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 Daily list of patients > 14 days length of stay Weekly capacity meeting involving all Head of Service & Matrons to review KPI's and hold to account	Transformation Emergency flow dashboard Throughput of discharge lounge Silver report analysis NED and CCG oversight at emergency flow steering group Division Performance reviews Independent report by CCG in December 2014 System Resilience Group Scrutiny	** ** ** ** *** ***	Pace of delivery of the emergency transformation programme following absences Poor clinical buy in to the programme Realigning single point of access Improving discharge process and reducing >14 day length of stay					Increased resources into the emergency transformation programme	
	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 From November, a Medical Day-case unit at the Kings Mill site to prevent inpatient admission & reduce LoS Additional middle grades establishment overnight Additional acute physician employed bringing total to 4	Divisional performance reviews ECIST review in December 2013 and follow up in June 2014 Independent report by CCG in December 2014 NED and CCG oversight at Emergency Flow Steering Group System Resilience Group scrutiny	** *** *** ** ***	Consistency in use of alternatives to admission by high use of locum medical staff Vacancies in substantive ED Consultant staff Streaming of patients in ED Realigning single point of access Poor utilisation of hot clinic/phone arrangements		3	3	9	Reduced reliance on locum medical staff Targeted usage of Medical Locum and agency staff Increase GP awareness of 'hot' services	

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						Daily Monitoring/reporting of breach analysis by reason									
	R4.4 Failure to achieve productivity and efficiency aims	Director of Operations	4	4	16	Newton Programme with defined benefits Elective transformation programme Robust job planning processes enacted during 2014 Rationalisation of escalation protocols to ensure patient safety and performance issues addressed Reduction in Length of Stay >14 days	Robust programme management arrangements – project board reports through steering group to the transformation board Divisional Performance reviews Independent report by CCG in December 2014 NED and CCG oversight at Emergency Flow steering group System Resilience Group scrutiny	** ** *** **	Pace of delivery of the programme Pace of enabling job plan changes		3	3	9	Increased resources into the Elective Transformation Programme Written communication of job plan changes instead of verbal consultation to agree changes The business case for Allocate software to enable robust job planning was approved at TMB in November 2014. A project team has been developed and is in place to implement the process	
	R4.5 Failure to manage and co ordinate 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 to track delivery of improvements Service line involvement of clinicians to review progress, develop actions and to track delivery of improvements Regular review meetings (weekly, daily)	Clinical involvement in both controls and the implementation of solutions Immediacy of actions taken to resolve current issue and alsot to prevent recurrence Changes tin process for certain cohorts of patients e.g. diabetic eyes are reflected positively through	* * *	Sustainable capacity (clinical and administrative) may not be achieved in all areas despite changes to practice etc. this may require resource	Lack of recent external evaluation of process, post migration of PAS	4	4	16	All services have an action plan to review and deliver a program of works. Each includes trajectory to recover and sustain. External revalidation requested from NUH and IST	

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						with external stakeholders (NHSE, CCG, Monitor, CQC) System to identify and prioritise patients at risk e.g. diabetic eyes, children who DNA An entry on to risk register	new reporting mechanisms Additional resources are in place to deliver increased controls together with long term improvements Capacity will be available through more accurate modelling of activity modelled into activity plan Monthly reports to Divisional Performance and Delivery Meetings with escalations to TMB where appropriate 18 week Intensive Support Team visit 2014 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, start date TBC 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.	Achievement of regional training centre status 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 31 Surveillance patients more than 6 weeks overdue as of 9/02/15		2	2	4	Action plan developed and tracked operationally Audit tool to be developed Offer appointments to overdue surveillance patients	

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						NHSI capacity and demand model completed									
	R4.7 Missing outcomes for outpatient attendances	Director of Operations	4	4	16	Weekly reports received to determine numbers of patients per specialty overdue and length of wait – sighted to problem Weekly review of progress and actions through RTT meetings – are our actions being successful Service line involvement of clinicians to secure capacity – reports discussed and actions drawn – are the action having the impact desired Identifying those at risk from a prolonged wait and ensuring we are managing those with highest risk first eg. diabetic eyes Action plans in place across all specialties Development of a failsafe process in children's service to prevent DNA's 'falling out' of the current system Patch testing and detailed requirements known to System C implementation group for agreement Escalation process if a clinical risk is identified following a delay Planning a trajectory to control and clear monitored weekly – interventions deployed An entry on to local risk register and corporate risk register	Clinical involvement in the problem Actions taken are to resolve current issue and also to prevent recurrence Long term changes to those patients who must have timely appointments e.g. diabetic eyes. This group have been removed from the partial booking process and will always receive an appointment within the time frame required. Use of technology to change pathway 'FLO' in urology follow up – nurse led PSA review clinic – measured through service improvement forum Modelled into activity planning 18 week Intensive Support Team visit 2014 Weekly CCG Performance Meetings	* * * ** ** **	Sustainable capacity may not be achieved in all areas despite changes to practice etc. – this may require resource		4	4	16	All services have an action plan to review and deliver a program of works. Each includes trajectory to recover and sustain. Depending on size of overdue patients and mobilisation of actions – some teams will recover quicker than others. Therefore the timeline ranges from Feb 15 through to May 15 to clear and sustain	
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	Exit Interview data – highlight future work priorities Internal Audit of recruitment processes – full review October 2013	** **	Robust system for talent management and succession planning Development and implementation of leaders to operate effectively in a service line management model. Gap analysis and development of 'middle		4	3	12	Develop and implement talent management and succession planning process • Requirement reference in Workforce Strategy, activity to commence • Develop and implement service line	

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						Leadership and Management Development Programmes – general staff, nursing and medical 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	and follow up May 2014 – Significant assurance for Recruitment and Retention and limited assurance for process TED Annual Report Regular feedback is received regarding the effectiveness of our leadership and management development offering Annual staff and quarterly Pulse surveys Appraisal outcomes Internal audit of Return to Work interviews – completed July/Aug 2014 – reported to Board of Director in September 2014	** ** *** ** ***	tier' managers Lack of comprehensive Leadership Strategy					management development programme Leadership Strategy in Development	
	R5.2 Low levels of staff satisfaction , health and wellbeing	Executive Director of HR	4	4	16	Sickness Absence rates and reasons for absence Health and Well-being group – subcommittee of OD and Workforce Committee Occupational Health Services	National NHS Staff Survey results 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 A5.2 Benchmark sickness absence data reported to Board of Directors	*** ** ** *** ** ***	Absences related to stress remains high		4	3	12	Enhanced support mechanism for staff who are absent with stress related illness Extensive communications campaign	

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						Action plans submitted resulting from 'Team Conversations'			Lack of evidence that Quality for All has been embedded across the Trust					to further engage managers in leading the implementation of Quality for All across the Trust	
	R5.3 Low levels of participation in training and appraisal	Executive Director of HR	4	4	16	Appraisal Policy & Procedure Appraisal training attendance records Monitoring of appraisal completion rates Mandatory Training Policy Monitoring of mandatory training attendance TED Strategy Annual completion of Training Needs Analysis and review of training programmes	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	Enhance reporting of appraisal data All staff have received personalised reports – evidence of increased booking on to programmes	
	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	Successful recruitment campaigns completed Local and International Recruitment Campaigns		Staff in post numbers remain below acceptable levels		4	3	12	Local and international recruitment campaigns for medical and nursing workforce 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	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 Junior Doctors forum act as informal early warning system Foundation trainees end of placement surveys TED Annual Report HEI Quality visits and outcomes	*** *** ** ** *** ** ***	Our ability to engage with trainees informally to identify potential patient safety/educational issues early		4	3	12	To develop informal sensing approaches with student nurses and AHP trainees to sense check the quality of their training and education. Medical Director to lead T&O team development sessions to help improve communication, behavioural standards and surgery site markings and consent process Development of the Radiology Team to improve communications and behaviours Improvement of variability of locum cover and senior support in ED Improvement in the recording of blood results on the ICE system	

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							Annual Health Education East Midlands annual quality review NMC Quality reviews of education provision	*** ***							

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