Sherwood Forest Hospitals
NHS Foundation Trust

Board Assurance Framework (BAF): October 2017

Introduction

The Board of Directors has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate risks which may threaten the achievement of the Trust's objectives. 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.

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for the effective and focussed management of Principal Risks to Trust objectives. The Board defines the Principal Risks and ensures that each is assigned to a Lead Director as well as to a Lead Committee:

- The Lead Director is responsible for assessing any Principal Risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the Lead Committee
- The role of the Lead Committee is to review the Lead Director's assessment of their Principal Risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the Lead Director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time
- The Board Risk Committee is responsible for reviewing the whole BAF in order to provide assurance to the Board that Principal Risks are appropriately rated and are being effectively managed; and for advising the Board as to the inclusion within the BAF of additional risks that are of strategic significance
- The Audit and Assurance Committee is responsible for providing assurance to the Board that the BAF continues to be an effective component of the Trust's control and assurance environment.

A guide to the criteria used to grade all risks within the Trust is provided in **Appendix I**.

Details of the Trust's vision, values and strategic priorities are provided in **Appendix II**.

OUR VISION

Dedicated people, delivering outstanding healthcare for our patients and communities

OUR STRATEGIC PRIORITIES

STRATEGIC PRIORITY 1: TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS

STRATEGIC PRIORITY 2: TO SUPPORT EACH OTHER TO DO A GREAT JOB

STRATEGIC PRIORITY 3: TO INSPIRE EXCELLENCE

STRATEGIC PRIORITY 4: TO GET THE MOST FROM OUR RESOURCES

STRATEGIC PRIORITY 5: TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES

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Strategic priority		1: TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS							
Ref	**Lead Director / Lead Committee**	**Principal risk**	**Inherent risk rating**	**Primary controls**	**Assurances**	**Residual risk rating**	**Gaps in control or assurance**	**Planned actions**	**Target risk rating**
AF1	Medical Director & Chief Nurse Quality Committee Last reviewed: September 2017	**Safe & effective patient care** If the Trust is unable to achieve and maintain the required levels of safe and effective patient care; Caused by inadequate clinical practice and / or ineffective governance; It may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.	Inherent likelihood: 5 (Very likely) Inherent consequence: 4 (High) **Inherent risk rating:** **20** **(Significant)**	Patient Safety & Quality Board (PSQB) monthly meetings and accountability structure of divisions and sub-groups. Senior leadership walk round programme. Clinical service structures, resources and governance arrangements in place at Trust, division and service line levels. Clinical policies, guidelines & pathways (Trust and national). Clinical audit programme and monitoring arrangements. Clinical staff recruitment, induction & mandatory training. Defined safe medical and nurse staffing levels for all wards and departments. Advancing Quality Programme (AQP) established. Nurse staffing safeguards, monitored twice daily by the Chief Nurse.	Chief Executive's Report to Board (November 2016): ▪ The Trust is now rated as 'Good' for Safety and Caring by the CQC Single Oversight Framework Report (September 2017): ▪ 94.80% harm free care during August against a standard of 95% ▪ 6 cases of Clostridium Difficile infection in August; above the monthly trajectory ▪ 1 MRSA bacteraemia in August; Trust responsibility accepted ▪ Continued reduction in % of falls per 1000 bed days compared to the equivalent point 13 months previously (5.78 in August against the national average of 6.63) ▪ Following improved Pressure Ulcer rates in June and July, August increased with two grade 2 PUs (within target) and 1 grade 4 (the first acquired within the trust for 25 months) ▪ The Trust remains compliant with same sex accommodation standards, reporting no breaches in August ▪ Inpatient responses for Friends & Family Test remain consistently above the national average (31.6% in August) ▪ The number of areas with red ratings (actual staffing level below the accepted 80% level highlighting a potential significant risk) saw a decrease to 6 wards in August 2017; the number with amber ratings (staffing fill rate is less than the accepted 90%, but above 80%) significantly decreased to 7 wards	Residual likelihood: 3 (Possible) Residual consequence: 4 (High) **Residual risk rating:** **12** **(High)** Previous residual risk rating: **8** **(Medium)** Residual risk rating last changed: **July 2016** Forecast trajectory (next 12 months): 	Addressing the potential for variation in outcomes (mortality, patient experience, length of stay and readmission rates) for patients admitted to hospital as an emergency.	Hospital 24 project (AQP), including standardisation of hospital management out of hours and partnership work as part of the Better Care Fund Seven Day Services Programme.	Target likelihood: 2 (Unlikely) Target consequence: 4 (High) **Target risk rating:** **8** **(Medium)**
							Building a safety culture to advance patient safety management.	Patient safety culture project (AQP), including implementation of Schwartz Rounding to maximise learning opportunities; & reinvigoration of the 'Sign Up to Safety' Campaign.	
							Identification and elimination of avoidable factors associated with inpatient mortality.	Mortality project (AQP) including implementation of a standardised approach to the Review of Mortality across all clinical areas.	
							Minimisation of risk associated with sudden and unexpected clinical deterioration.	Nerve Centre project (AQP) - implementation of a Trust-wide system for identifying and responding to the deteriorating patient.	
							Reducing risk associated with medicines by focussing on senior review and controls for managing high-risk medicines.	Safe medicine prescribing project (AQP) including implementation of a pharmaceutical record for all patients and prevention of antimicrobial resistance.	
							Delivery of safe, seamless care for those admitted to hospital as an emergency who are learning disabled or have ongoing mental health needs.	Mental health & learning disabilities project (AQP) including creation of an 'In your shoes' approach to fully understand the patient journey, and partnership working to agree appropriate pathways.	
							Empowering and engaging service users by improving the quality of and access to patient information	Patient information project (AQP) including creation of a single point of access in line with the Trust Digital Strategy.	

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Strategic priority		1: TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS							
Ref	**Lead Director / Lead Committee**	**Principal risk**	**Inherent risk rating**	**Primary controls**	**Assurances**	**Residual risk rating**	**Gaps in control or assurance**	**Planned actions**	**Target risk rating**
AF2	Chief Operating Officer Quality Committee Last reviewed: September 2017	**Managing emergency demand** If the Trust is unable to manage the level of emergency demand; Caused by insufficient resources and / or fundamental process issues; It may result in sustained failure to achieve constitutional standards in relation to A&E; significantly reduced patient flow throughout the hospital; disruption to multiple services across divisions; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.	Inherent likelihood: 5 (Very likely) Inherent consequence: 4 (High) **Inherent risk rating:** **20** **(Significant)**	Emergency demand & patient flow management arrangements: ▪ Patient flow team ▪ 4 times a day Flow meetings chaired by DNM, silver or Gold depending upon level of escalation. ▪ Daily Board rounds ▪ Weekly Breach meetings ▪ Daily review of DTOCs & process for medically optimised patients ▪ Robust escalation protocols ▪ DTOC meetings 3 times per week with system wide partners ▪ Review of all patients with a length of stay of over 10 days Emergency Department (ED) standard operating procedures. Single streaming process for ED & Primary Care. Monthly performance management meetings between Divisions and Service Lines, and between Divisions and Executive Team. ▪ Daily monitoring of performance against the 4 hour A&E standard ▪ Weekly monitoring of information on re-admissions ▪ Weekly monitoring of information on average length of stay and bed occupancy ▪ Daily monitoring of information on Delayed Transfer of Care (DTOC) ▪ Quarterly monitoring of patient satisfaction (compliments, concerns & complaints Bi-weekly System Resilience Group meeting (multi-agency). Trust attendance at A&E Board and regular engagement with the Chair	Chief Executive's Report to Board (November 2016): ▪ SFH is currently recognised as one of the best performing Trusts for emergency waiting times in the country Single Oversight Framework Report (September 2017): ▪ Having achieved the four-hour emergency care standard (patients seen, treated and discharged or admitted within 4 hours of arrival) for five consecutive months (March – July 2017), Trust performance in August was 94.6% ▪ The key reasons for underperformance related to medical staffing overnight in the Emergency Department ▪ Handing over a patient from an ambulance to an ED is expected to take no more than 15 minutes; in August, 11.8% of ambulance handovers took between 15 and 59 minutes and 0.3% took 60 minutes or more ▪ There were no patients in August who waited 12 hours or more for an emergency admission from the time the decision is made to admit or when treatment in ED was completed	Residual likelihood: 4 (Somewhat likely) Residual consequence: 4 (High) **Residual risk rating:** **16** **(Significant)** Previous residual risk rating: **12 (High)** Residual risk rating last changed: **September 2017** Forecast trajectory (next 12 months): 	Planned system-wide actions may not have the desired outcomes of reducing ED attendances and reducing delays in discharging or transferring patients. Impact of reduced social care funding. Impact of year on year rise in emergency demand & ability of the Trust to respond with current resources. Increased patient acuity leading to more admissions & longer length of stay.	Proactive system leadership engagement from SFH into Better Together Alliance Delivery Board. Rolling recruitment programmes in place to address vacancy issues. Exploration of the potential for joint clinical working between NUH and SFH in some services. Length of stay work-stream project (AQP) focussing on proactive discharge planning, with schemes to increase ambulatory care and admission avoidance. Implementation and embedding of admission avoidance schemes: ▪ Respiratory Assessment Unit - implemented ▪ Frailty Assessment Unit (pilot being planned) ▪ Clinical Decisions Unit (CDU)	Target likelihood: 2 (Unlikely) Target consequence: 4 (Low) **Target risk rating:** **8** **(Medium)**

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Strategic priority		1: TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS							
Ref	**Lead Director / Lead Committee**	**Principal risk**	**Inherent risk rating**	**Primary controls**	**Assurances**	**Residual risk rating**	**Gaps in control or assurance**	**Planned actions**	**Target risk rating**
AF3	Chief Operating Officer Quality Committee Last reviewed: September 2017	**Managing elective demand** If the Trust is unable to manage the level of elective demand; Caused by insufficient resources and / or fundamental process issues; It may result in sustained failure to achieve constitutional standards in relation to access; substantial delays to the assessment and treatment of multiple patients; increased costs; financial penalties; unmanageable staff workloads; and possible breach of license.	Inherent likelihood: 5 (Very likely) Inherent consequence: 4 (High) **Inherent risk rating:** **20** **(Significant)**	Patient pathway management arrangements: ▪ Medway PAS – Patient Administration System ▪ Patient Tracking List (PTL) - weekly meetings & associated training ▪ Validation process & dedicated resources Standard operating procedures for diagnostic services. Monthly performance management meetings between Divisions and Service Lines, and between Divisions and Executive Team: ▪ Monitoring of performance against Referral to Treatment (RTT) standards ▪ Monitoring of performance against diagnostic (DM01) standards ▪ Monthly information on cancellations of elective activity Monthly Cancer Management Board meetings: ▪ Monitoring of performance against cancer standards Bi-weekly System Resilience Group meeting (multi-agency membership).	Single Oversight Framework Report (September 2017): ▪ The Trust consistently achieves above the RTT (Referral to Treatment) waiting times standard of 92% ▪ Overall performance is at 92.1% ▪ The standard is not being achieved in 8 specialties, which is likely to continue in some specialties for a number of months as the actions required to ensure sustainability require either a system wide or partnership solution to staffing capacity issues ▪ 52 week breaches continue to be reported due to the ongoing validation of all clock stops; however, there are currently no patients on the PTL above 45 weeks ▪ Diagnostic waiters performance in August 2017 was 98.2% against the 99% standard; the standard was achieved in 7 tests out of 12 ▪ 62 day referral to treatment from screening for cancer performance was 85.7% in July against the standard of 90%; the breach related to one patient ▪ Performance against the 62 days urgent referral to treatment for cancer standard was 81.3% in July against the standard of 85%, this related to 19 patients breaching the standard	Residual likelihood: 3 (Possible) Residual consequence: 4 (High) **Residual risk rating:** **12** **(High)** Previous residual risk rating: **16** **(Significant)** Residual risk rating last changed: **May 2016** Forecast trajectory (next 12 months): 	Sustainability of Urology, Neurology and ENT services.	Mobilisation of revised clinical models for Urology and Neurology (subject to Board approval). Development of joint SFH / NUH model for ENT.	Target likelihood: 2 (Unlikely) Target consequence: 4 (Low) **Target risk rating:** **8** **(Medium)**
							Vacancy and resilience issues within some clinical services.	Rolling recruitment programmes in place to address vacancy issues. Exploration with NUH and other providers of the potential for joint clinical working and support in certain services.	
							Not all clinical services are currently performing to the same level.	Development & implementation of action plans for all areas which are currently not meeting required standards. Action plan for cancer recovery. Action plans for RTT & DM01.	
							Clinical services delivered in partnership: Vascular; Oncology; Stroke.	Strengthening of Service Level Agreements (SLAs) via Strategic Partnership Board for affected services.	
							Resilience of Central Sterile Services Department (CSSD).	CSSD options appraisal being carried out through the Strategic Partnership Board.	

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Strategic priority		4: TO GET THE MOST FROM OUR RESOURCES							
Ref	**Lead Director / Lead Committee**	**Principal risk**	**Inherent risk rating**	**Primary controls**	**Assurances**	**Residual risk rating**	**Gaps in control or assurance**	**Planned actions**	**Target risk rating**
AF4	Chief Financial Officer Finance Committee Last reviewed: September 2017	**Financial sustainability** If the Trust is unable to achieve and maintain financial sustainability; Caused by the scale of the deficit and the effectiveness of plans to reduce it; It may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention.	Inherent likelihood: 5 (Very likely) Inherent consequence: 5 (Very high) **Inherent risk rating:** **25** **(Significant)**	5 year long term financial model. Working capital support through agreed loan arrangements. Annual plan, including control total consideration and reduction of underlying financial deficit. Engagement with the Better Together alliance programme. Financial governance and performance arrangements in place at Trust, divisional and service line levels and with contracted partners. CIP Board, CIP planning processes and PMO coordination of delivery.	NHS Improvement monthly Performance Review Meeting (PRM) & PRM letter. NHSI have approved a £1.8m increase in the Trust's Control Total for 2017/18. Single Oversight Framework Report (September 2017): ▪ In month 5 the Trust was £0.08m worse than plan and cumulatively £0.01m better than plan ▪ Clinical income was in line with plan in August; YTD clinical income is £0.1m worse than plan ▪ Other operating income is £0.2m favourable to plan in month and £0.1m favourable to plan YTD relating primarily to NHIS ▪ Expenditure in month was £0.2m worse than plan and in line with plan YTD ▪ Overall CIP is £0.2m worse than plan YTD; most significant slippage is against the internal patient flow workstream ▪ The STP element of the CIP target YTD is £1.9m which has been offset on a non-recurrent basis by SFH mitigations including the control total adjustment and interest payment benefits ▪ Agency spend was £1.3m in month, a reduction of £0.2m compared to July and below the NHSI agency ceiling ▪ The capital loan has been delayed and was formally submitted by NHSI to DOH for review and approval 18th September 2017	Residual likelihood: 3 (Possible) Residual consequence: 5 (Very high) **Residual risk rating:** **15** **(Significant)** Previous residual risk rating: **10** **(High)** Residual risk rating last changed: **November 2016** Forecast trajectory (next 12 months): 	2017/18 CIP requires £6m savings driven by STP actions.	Close working with STP partners and the Alliance framework to identify system-wide cost reductions that will enable achievement of the CIP.	Target likelihood: 2 (Unlikely) Target consequence: 5 (Very high) **Target risk rating:** **10** **(High)**
							No long term commitment received for liquidity / cash support.	Continue to work in partnership with NHSI Distressed Finance Team to submit in year applications for cash support.	
							Premium pay costs associated with using temporary staff to cover medical vacancies.	Development & implementation of a Medical Pay Task Force action plan.	
							Effectiveness of budget management and control at division and service line levels.	Continued delivery of budget holder training workshops and enhancements to financial reporting.	
							CCGs' QIPP and Better Together alliance initiatives may reduce demand and therefore income at a faster rate than the Trust can reduce costs.	Working within the agreed alliance framework and contracting structures to ensure the true cost of system change is understood and mitigated.	
							The CCG has issued notice on services supported by block funded income; if the Trust is unable to strip out the associated capacity and related costs this will impact on financial performance; if the Trust does strip out the associated capacity, this may impact on quality and operational performance, which may lead to further cost pressures.	PMO leading completion of business impact assessments by divisions. CCG/Trust Exec Teams discussions on-going to ensure that the CCG is clear on risks associated with the notices, that any financial implications (such as redundancy) are met by the Mid-Notts Health Economy, and to gain assurance that the quality and performance risks are fully understood and managed.	

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Strategic priority		2. TO SUPPORT EACH OTHER TO DO A GREAT JOB							
Ref	**Lead Director / Lead Committee**	**Principal risk**	**Inherent risk rating**	**Primary controls**	**Assurances**	**Residual risk rating**	**Gaps in control or assurance**	**Planned actions**	**Target risk rating**
AF7	Director of HR & OD OD & Workforce Committee Last reviewed: September 2017	**Staffing levels** If the Trust is unable to achieve and maintain staffing levels that meet service requirements; Caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience; It may result in extended unplanned service closures and disruption to services across divisions, leading to poor clinical outcomes & experience for large numbers of patients; failure to achieve constitutional standards; unmanageable staff workloads; and increased costs.	Inherent likelihood: 5 (Very likely) Inherent consequence: 4 (High) **Inherent risk rating:** **20** **(Significant)**	Workforce Strategy supported by vacancy management and recruitment systems & processes. Annual workforce plan supported by Workforce Planning Group & review processes: ▪ Consultant job planning matching capacity to demand ▪ Detailed modelling of nurse staff & HCSW's in post v establishment, to predict future vacancy trajectory - monthly ▪ Nurse staffing establishment review – 6 monthly ▪ Winter capacity plans ▪ 6 monthly acuity & dependency assessments to ensure staffing is targeted to demand ▪ Developing a plan for new roles Defined safe medical & nurse staffing levels for all wards & departments; 36 WTE HCSW's above establishment in virtual ward. Updated recruitment branding and approach involving social media and assessment days. Temporary staffing approval and recruitment processes with defined authorisation levels. TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation. Increased use of Clinical Fellows to c50 in the Trust	Single Oversight Framework Report (September 2017): ▪ Sickness absence figures increased slightly in August 2017 by 0.03% to 3.46%; this is now the second month in a row which is below the sickness absence target of 3.5% ▪ Short term sickness was 1.81% (July 2017, 1.76%) and long term sickness was 1.64% which is a reduction of 0.03% (July 2017, 1.67%) ▪ Across the Trust, there were 16.73 FTE more starters than leavers in August 17 (47.95 FTE starters v 31.22 FTE leavers) ▪ The turnover rate decreased to 0.79% in August (July, 0.87%) ▪ The Scientific and Professional group has increased from 10.22% to 14.77% vacancies since April 2017, although some of this is due to a slight increase in establishment. Turnover is still above the Trusts threshold of 1%. However, there were more starters than leavers in August ▪ This month 5.00 FTE doctors have gone from bank only contracts to substantive or fixed term contracts ▪ Band 5 Registered Nurse vacancies have increased by 1.64% to 19.77% ▪ Trust wide appraisal compliance was 93% for August 2017, remaining the same for the third month in succession ▪ Mandatory training has increased to 93% for August 2017 (July 92%)	Residual likelihood: 4 (Somewhat likely) Residual consequence: 4 (High) **Residual risk rating:** **16** **(Significant)** Previous residual risk rating: **Unchanged** Residual risk rating last changed: **Unchanged** Forecast trajectory (next 12 months): 	Availability of required skills within the employment market; national shortage of some specialists.	Alternative solutions being sought for 'Hard to Fill' medical posts. International recruitment of Registered Nurses and on-going recruitment of newly qualified nurses.	Target likelihood: 2 (Unlikely) Target consequence: 4 (High) **Target risk rating:** **8** **(Medium)**
							Robustness of the system for talent management and succession planning.	Development of future talent management processes. CSAR scheme for medics – rotational training to develop future consultants.	
							Understanding of medical staffing models to enable planning for future supply to meet demand.	Detailed modelling of medical staff in post v establishment, attrition rates and recruitment plans to predict future supply. Roll-out of Clinical Activity Manager (CAM) system.	
							Initiatives to increase nursing and medical locum bank.	Introduced a weekly payroll. Revised nursing and medical bank rates. Rolling out Allocate for medical locum bank management.	
							IR35 legislative changes (affecting intermediaries / contractors) require new systems to ensure compliance and may have an impact on locum / interim market.	IR 35 taskforce daily operational meeting mainly to address immediate medical workforce supply challenges.	
							Variability of Deanery supply creates junior doctor vacancies that have to be filled using locums.	Approved strategy of over-recruitment to create a pool of junior doctors that is more resilient to Deanery variations.	

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Appendix I: Risk grading criteria

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Consequence (the scale of impact on objectives if the risk event occurs) and its Likelihood (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

	Consequence score & descriptor with examples				
Risk type	**Very low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very high 5**
a. Patient harm or **b. Staff harm** or **c. Public harm**	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: Discomfort.	Minor, short term injury or illness, requiring non-urgent clinical intervention (e.g. extra observations, minor treatment or first aid). e.g.: Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. Grade 2 or3 pressure ulcer. Healthcare associated infection (HCAI). Noticeable adverse reaction to medication. RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual. e.g.: Loss of a limb Permanent disability. Severe, long-term mental illness. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments after surgery. Severe allergic reaction to medication.	Multiple fatal injuries or terminal illnesses.
d. Services	Minimal disruption to peripheral aspects of service.	Noticeable disruption to essential aspects of service.	Temporary service closure or disruption across one or more divisions.	Extended service closure or prolonged disruption across a division.	Hospital or site closure.
e. Reputation	Minimal reduction in public, commissioner and regulator confidence. e.g.: Concerns expressed.	Minor, short term reduction in public, commissioner and regulator confidence. e.g.: Recommendations for improvement.	Significant, medium term reduction in public, commissioner and regulator confidence. e.g.: Improvement / warning notice. Independent review.	Widespread reduction in public, commissioner and regulator confidence. e.g.: Prohibition notice.	Widespread loss of public, commissioner and regulator confidence. e.g.: Special Administration. Suspension of CQC Registration. Parliamentary intervention.
f. Finances	Financial impact on achievement of annual control total of up to £50k	Financial impact on achievement of annual control total of between £50 - 100k	Financial impact on achievement of annual control total of between £100k - £1m	Financial impact on achievement of annual control total of between £1 - 5m	Financial impact on achievement of annual control total of more than £5m

Likelihood score & descriptor with examples				
Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Less than 1 chance in 1,000 Statistical probability below 0.1% Very good control	Between 1 chance in 1,000 and 1 in 100 Statistical probability between 0.1% - 1% Good control	Between 1 chance in 100 and 1 in 10 Statistical probability between 1% and 10% Limited effective control	Between 1 chance in 10 and 1 in 2 Statistical probability between 10% and 50% Weak control	Greater than 1 chance in 2 Statistical probability above 50% Ineffective control

Risk scoring matrix						
Consequence	**5**	**5**	**10**	**15**	**20**	**25**
	4	**4**	**8**	**12**	**16**	**20**
	3	**3**	**6**	**9**	**12**	**15**
	2	**2**	**4**	**6**	**8**	**10**
	1	**1**	**2**	**3**	**4**	**5**
		1	**2**	**3**	**4**	**5**
		Likelihood				

Rating	Very low (1-3)	Low (4-6)	Medium (8-9)	High (10-12)	Significant (15-25)
Oversight	Specialty / Service level Annual review		Division Quarterly review		Committee / Board Monthly review
Reporting	None			Board Risk Committee	

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Appendix II: Vision, values & strategic priorities

OUR VISION

Dedicated people, delivering outstanding healthcare for our patients and communities

OUR VALUES

In fulfilling our vision we will be guided by our organisational values

Communicating and working together

We will proactively engage with each other, share information, keep people informed, listen and involve people and work as one team

Aspiring and improving

We will set high standards, give and receive feedback in order to learn, keep improving and aspiring for excellence

Respectful and caring

We will treat everyone with courtesy and respect, show care and compassion, support and value each other

Efficient and safe

We will act competently and be reassuringly professional, demonstrate reliability and consistency to engender confidence, and be efficient and timely and respectful of other's time

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OUR STRATEGIC PRIORITIES

STRATEGIC PRIORITY 1 TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS	1

- Through enabling and supporting our staff to deliver outstanding care to our patients and local communities that is recognised nationally as the very best clinical practice
- By listening to our patients, their relatives, and carers and our staff we will learn how we can improve their experience and the care we provide.
- Through caring for every patient in the timeliest fashion, listening to and understanding their needs, keeping them informed and ensuring they understand fully what is needed for their on-going care once they leave hospital.
- Through the commitment that admission avoidance and the timely flow of patients through our hospitals is everybody's job because it saves lives

STRATEGIC PRIORITY 2 TO SUPPORT EACH OTHER TO DO A GREAT JOB	2

- We will aim to attract, nurture, develop and enable our people and teams to support each other and work together to deliver outstanding care.
- We will expect everyone and every team to do the very best for our patients, to live our values, to make positive change happen and to aspire to fulfil their potential and be the best they can.

STRATEGIC PRIORITY 3 TO INSPIRE EXCELLENCE	3

- We will take pride in all we do, celebrate and share our success and achievements and build our reputation for outstanding care.
- We will constantly seek out and promote innovation, enhance our practice, optimise the use of technology and engage in clinical research for the benefit of patients and staff.

STRATEGIC PRIORITY 4 TO GET THE MOST FROM OUR RESOURCES	4

- We will aim to get the most from our use of time and resources - being radical in our approach, challenging and supporting each other to do things differently to reduce costs and maximise our productivity and efficiency.

STRATEGIC PRIORITY 5 TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES	5

- We will play a leading role, with our partners in health, local government and other sectors, in transforming services to improve the health and wellbeing of our communities, to support care at home and independent living.