

Agenda Item:

Board of Directors Meeting

Report

Subject: Board Assurance Framework

Date: 30th January 2014

Author: Shirley A Clarke, Head of Programme Management / Shelley Watson Interim Head of Risk

Lead Director: Kerry Rogers – Director of Corporate Affairs/Company Secretary

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enables the board to gain assurance about the effectiveness of these controls.

This report describes progress made regarding reviewing the BAF since the last report to Board in October 2013. The BAF was reviewed at the Risk Assurance Committee in January 2014, further work has been undertaken since this review to ensure alignment with the Corporate Risk Register this is reflected in the BAF attached at appendix A.

Further work needs to be undertaken to ensure both the BAF and Corporate Risk Register are fit for purpose. This will enable the Board to make informed decisions regarding the achievement of the Trusts Strategic Objectives

Recommendation

The Board is invited to note and approve the changes identified on the BAF summary report.

The Board is invited to request a further review of the BAF and Corporate Risk register for approval at the Risk Assurance Committee in February with a subsequent report to Board.

Relevant Strategic Objectives (please mark in bold)

Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register

A corporate risk register is currently being developed which will align to the BAF. In future a reference number will be provided for each risk demonstrating

	alignment to the Corporate Risk Register
Details of additional risks associated with this paper (<i>may include CQC Essential Standards, NHSLA, NHS Constitution</i>)	The BAF can also be aligned to the outcomes contained within the CQC Essential Standards.
Links to NHS Constitution	Links to the NHS Constitution – principle 7 – NHS is accountable to the public and should therefore transparently take responsibilities for services. The NHS also commits to ensure continuous improvement of services.
Financial Implications/Impact	Risks associated with objective 4 (Financial and commercial sustainability) may have implications for the Monitor Compliance Framework
Legal Implications/Impact	Risks associated objectives 1 & 2 can impact on compliance with CQC outcomes. Financial risks may affect compliance with the Monitor Framework 2013/14
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	The BAF is submitted to the Risk Assurance Committee monthly Audit Committee 18 July 2013 Executive Team Meeting 15 July 2013 The BAF was developed with support from KPMG in May 2013
Monitoring and Review	Monthly at Risk Assurance Committee At least 4 times a year at Board of Directors meetings
Is a QIA required/been completed? If yes provide brief details	

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1. Introduction

The Trust Board's main focus is strategic. Board members must understand the strategic objectives and be able to identify the principal risks which may threaten the achievement of these objectives. The board's role therefore is to focus on those risks which may compromise the achievement of the strategic objectives.

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enables the board to gain assurance about the effectiveness of these controls.

This report describes progress made regarding reviewing the BAF since the last report to Board in October 2013. The BAF was reviewed at the Risk Assurance Committee in January 2014, further work has been undertaken since this review to ensure alignment with the Corporate Risk Register this is reflected in the BAF attached at appendix A.

Further work needs to be undertaken to ensure both the BAF and Corporate Risk Register are fit for purpose. This will enable the Board to make informed decisions regarding the achievement of the Trusts Strategic Objectives.

The BAF summary below provides an analysis of the risks which threaten the achievement of the strategic objectives. This summary identifies new risks, the removal of previous risks and the changes in risk levels since the October Report.

Board Assurance Framework

The BAF is aligned to the following five strategic priorities as outlined in the 2013/14 business plan:

1. Achieve the best patient experience
2. Improve patient safety and provide high quality care
3. Attract, retain and motivate an appropriately trained workforce

4. Financial sustainability
5. Excellent relationships with external organisations/regulators

As a Foundation Trust it is important that the BAF works as a tool to support the Board's assurances in terms of self-certification on compliance with the Terms of Authorisation.

An Executive Director is allocated responsibility for each principal risk and is required to update the BAF to reflect the mitigating actions and controls which have been implemented.

It is the duty of the Board to ensure that assurances are robust and that action plans to address gaps in assurance and/or controls are appropriately prioritised, monitored and progressed.

Scrutiny is important to the Assurance Framework process and the organisation's strategic risks must be reviewed and challenged systematically.

From April a strengthened approach to deliver more robust assurance on the quality of control effectiveness will commence with Audit Committee becoming the custodian of the BAF strategically aligning it to the Annual Governance Statement and focusing the board's agenda on strategic risk imperatives

Recommendations

The Board is invited to note and approve the changes identified on the BAF summary report.

The Board is invited to request a further review of the BAF and Corporate Risk register for approval at the Risk Assurance Committee in February with a subsequent report to Board.

BOARD ASSURANCE FRAMEWORK – SUMMARY					
	BAF Risk No:	October Risk Level	January Risk Level	Risk Change in Period	Comments
Strategic Objective 1: Achieve the best patient experience					
Failure to communicate effectively with patients and their GP's	1.1	12	8	↓	
Retained estate is not fit for purpose	1.2	12	12	↔	
Failure to implement processes and procedure to ensure robust timely management of complaints	1.3	12	6	↓	
Failure to manage patient pathway	1.4	-	15		New Risk
Strategic Objective 2: Improve patient safety and provide high quality care					
Failure to reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) indicator by 10% during 2013/14 (baseline HSMR at 01/04/13=116)	2.1	20	20	↔	
Failure to reduce patient harms which include pressure ulcers, falls, medication errors and hospital acquired infections	2.2	12	12	↔	
Failure to deliver improvements in care quality required by external regulatory reviews (Keogh & CQC) and contractual requirements (Quality Schedule & CQUIN)	2.3	16	12	↓	
Failure to implement preventative measure resulting in a serious largely preventable safety incident (never event)	2.4	-	10		New Risk
Strategic Objective 3: Attract, develop and motivate effective teams					
Failure to appropriately manage and train staff to carry out their work	3.1	16	12	↓	
Failure to attract appropriately skilled staff	3.2	-	20		New Risk
High levels of clinical posts filled using temporary staff	3.3	16	16	↔	
Failure to deliver strategic objectives	3.4	6	6	↔	
Failure to develop clinicians' into effective managers in the Trust	3.5	12	12	↔	

Strategic Objective 4: Achieve Financial Sustainability					
Failing to find a solution to PFI Excess burden	4.1	20	20	↔	
Insufficient cash liquidity	4.2	10	10	↔	
Failure to have an agreed financial improvement plan	4.3	20	20	↔	
Failure to adequately performance manage the agreed operational and financial plan	4.4		20		New Risk
Reduced funding from Commissioners	4.5	20	20	↔	Replaces previous 4.4
Failure of delivery of year on year CIP	4.6	20	20	↔	
Lack of financial Management across the Trust	4.7	-	20		New Risk
Strategic Objective 5: Excellent relationships with external organisations / regulators					
Planned restructure of services identified in the Mid Nottinghamshire transformation review					Risk removed from BAF
Communication and engagement channels need to be strengthened with health and social care partners	5.1	12	9	↓	Previously 5.2
Clinical strategy does not fully reflect the requirements of commissioners and other stakeholders	5.2	12	12	↔	
Failure to rectify governance failings and emerge from breach of authorisation	5.3	16	12	↓	

Sherwood Forest Hospitals Foundation Trust Board Assurance Framework

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Objective	Risk no.	Risk description	Cause	Consequence	Risk owner	Gross impact	Gross likelihood	Gross RAG Status	Existing controls	Sources of assurance	Expiry date	Gaps in assurance	Net impact	Net likelihood	Net RAG Status	Action for further control	Action owner	Due date	Movement from prior assessment
What is the Trust's objective?	Risk ref	Describe the risk which threatens the achievement of the objective	What might cause the risk to occur?	What are the possible consequences if the risk occurs?	Individual ultimately accountable for managing the risk	Rating of 1 to 5	Rating of 1 to 5	ixL	What existing controls and processes are in place to manage the risk?	What positive assurances are there? What benefits have these brought?	When is the assurance valid until?	What has not yet been done?	Rating of 1 to 5	Rating of 1 to 5	ixL	What further action (if any) is necessary to address the gap?	Who is responsible for this action?	When must it be completed?	Red / Amber / Green
Strategic Objective 1: Achieve the best patient experience.	1.1	Clinical risk including medication risks and risk of failing to update care plan for patients due to not communicating effectively with patients and their GPs within agreed timescales	Increase in number of complaints and PALS concerns reported by patients and carers Patient administration systems not operating correctly. Systems for sharing patient information with GPs not operating correctly. History of patient if seen in clinic again may not be as up to date as needed.	Increased delays in arranging patient appointments leading to poor patient experience. Failure to promptly share patient information with GPs leading to delayed treatment, inappropriate care and potential impact on clinical outcomes.	Medical Director	4	4	16	Additional temporary typing staff recruited. WinScribe has been implemented and fully rolled out to manage and measure workload. Turnaround plans in place to achieve: - 5 day target by 31/10/13 - achieved by 31st July 2013.	Monthly typing up report to CGC provides performance overview Survey of GPs informs assessment of progress. Turnaround plan in respect of the 5 day target is managed via the performance contract	31/10/13 for 5 day target	New structure now in place, daily monitoring being undertaken	4	2	8	Monitor and assess progress in delivery of turnaround plan to achieve the 10 and 5 day targets, implementing remedial action where necessary. Complete consultation on revised administrative structure and secure successful implementation of the new structure. Ensure clinical risks are assessed by clinical teams and appropriate prioritisation takes place. Robust monitoring on regular basis until confident.	Director of Operations	31/10/2013 - review of schedule taking place in November.	
	1.2	Retained estate is not 'fit for purpose'. Risk to service interruption and risk of poor patient experience due to required improvements needed to update infrastructure	Insufficient investment in the capital programme to replace/refurbish retained estate. Lack of ability to fully finance required developments.	Increased estate maintenance and running costs. Reduced service quality through use of retained estate.	Executive Director of Strategic Planning and Commercial Development	4	3	12	In year investment in high risk estate areas. Improved links between the Corporate and Divisional risk management processes to identify, manage and address risks in a coherent and joined up manner	Weekly project team meetings Monthly Project Board Regular Board and HMB reports	Review 3/14	Clinical Strategy is currently being developed - will be completed by October 2013 Estates Strategy will be completed by December 2013	4	3	12	Clinical Estates Strategy to be finalised by 30/11/13 but emerging themes to be identified by 30/09/13 Estates rationalisation programme needs to be developed on the back of the Clinical Estates Strategy.	Head of Estates and Facilities	30/09/13 for emerging themes 30/11/13 for Strategy and Estates Rat Programme	
	1.3	Failure to implement process and procedures to ensure robust timely management of Complaints	Failure to meet commitment to patient care and principles of NHS constitution Failure to be compliant with CQC registration requirements	Reduced service quality and opportunities for lessons learnt/service improvement Reputational impact	Director of Nursing	4	4	16	Complaints team have been strengthened with 1 specialist interim complaints manager overseeing the team. Performance management tool/spreadsheet - assessed weekly as a minimum Daily dialogue between divisions and complaints team New process for complaints management currently progressing through a workforce change process	Complaints backlog is now cleared. Quarterly reporting on performance and themes to Trust Board via Patient Experience Report	ongoing	New complaints & PALS structure being re-designed and will involve re-structure of teams to ensure the new process can be implemented but Divisional Teams have given their commitment to continuing with current processes until new process implemented	3	2	6	Implementation of the new process following workforce change process. Updated complaints policy	Director of Nursing	April 2014 for implementation of new process following consultation	
	1.4	Failure to manage the patient pathway	Not having effective processes for managing 18 week pathway in PPC specialties. Lack of safe operating	Timeliness of diagnosis, poor management of patient pathway	Medical Director	5	4	20	Additional staff training in 18 weeks. SOP's in place.	18 week management. Validation of 18 weeks. Unanswered telephone log. ICPI's	01/11/2013	Full training. Roll-out of Winscribe II	5	3	15	Monitoring of progress	Director of Operations	Nov-13	

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Strategic Objective 2: Improve patient safety and provide high quality care.	2.1	Failure to reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) indicator by 10% during 2013/14 (baseline HSMR at 01/04/13 = 116)	Clinical strategies and policies not aligned to enable reduction in HSMR. No clear actions identified to reduce HSMR. Insufficient action taken to reduce HSMR to target level. Lack of clinical engagement and staff understanding to enable improvements in care to be made	Detrimental impact on patient care and clinical outcomes. Potential reduction in public confidence which will impact on primary care referral patterns and commissioning including potential loss of business. Linked to this a loss of income which could lead to certain services no longer being economically viable.	Executive Medical Director	5	5	25	Trust wide mortality action plan has been developed and is on track Internal Mortality Group has been established with responsibility for implementing actions to reduce HSMR Joint CCG and Trust Mortality Group continues to meet to monitor progress and initiate remedial action where appropriate. PwC Diagnostic work has strengthened internal HSMR Action Plan. Monthly monitoring of HSMR through the use of Dr Foster data. Clinical and operational workstreams established tasked to implement actions to reduce HSMR. Associate Medical Director for Patient Safety has been appointed. Patient Safety Lead has been appointed to focus on key deliverables. The action plan based on keogh recommendations is being implemented which will influence mortality rates	Monthly reports to Trust Board outlining progress in reducing HSMR and assessing performance to date in delivery of the workstream action plans Monthly reports to Joint CCG and Trust Mortality Group. PwC Diagnostic work has strengthened internal HSMR Action Plan. External reviews which assessed specific issues have been undertaken and identified areas of good practice. HSMR has shown improvement based on the figures received in September 2013	30/11/2003	Vitalpac electronic monitoring system has been supported and the project is currently being established.	5	4	20	Develop an implementation plan for Vitalpac within next three months with full roll out of the system by the end of the current financial year. Continue to implement and monitor the delivery of the action plan relating to Keogh and the Trust mortality action plan Reinstate the Patient Safety Steering Group to oversee progress across all mortality workstreams. Consider appointment of patient safety fellow to support work.	ITC Service Lead CEO Each action has an assigned executive lead and responsible manager. Associate Director of Patient Safety	Full implementation by the end of Dec 2014 Each specific action has a completion date and progress is monitored at a weekly project meeting. Executive review of the action plan is undertaken at programme Management Board October 2013	Red
	2.2	Failure to reduce patient harms which include pressure ulcers, falls, medication errors and hospital acquired infections	Insufficient capacity to ensure training needs are met Insufficient resources to make improvements needed to reduce harm rates	Failure to deliver improvements in quality to meet Trust priorities and contractual requirements from CCG Failure to instill confidence in general public, governors	Executive Director of Nursing & Executive Medical Director	4	4	16	Ward assurance dashboard set up to facilitate the monitoring of measures. FOCUS IT tool set up to enable clinical teams to review performance and set actions which can then be monitored by the management teams Establishment of medicines safety project and recruitment of falls nurse	Improvement in pressure ulcer performance during last 3 months	31st October 2013	IT system refinement and development to facilitate the monitoring of harms information	4	3	12	Work with IT to develop tool to enable clinicians to track and monitor performance	Deputy Director of Nursing & Associate Medical Director	Mar-14	

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	2.3	Failure to deliver improvements in care quality required by external regulatory reviews (Keogh & CQC) and contractual requirements (Quality Schedule & CQUIN).	Insufficient capability and capacity to deliver improvements within the accelerated timescales Inability of clinical teams to implement reduction strategies Lack of project resources to drive improvements	Inability to meet improvement targets and standards identified. Risk to Registration with CQC. Reputational risk which impacts on patient choice, staff choosing to work at SFH and confidence of commissioners	Executive Director of Nursing & Executive Medical Director	5	4	20	Weekly project meetings to review progress of action plans Programme Management Office supporting and ensuring robust project management Additional resource to support delivery of selected key actions Actions plans being integrated to bring together Keogh, PWC and CQC recommendations Immediate increase in nursing staffing levels at night introduced post Keogh Summit	Action plan on track and being scrutinised at Programme Management Board Positive assurance from CQC - Compliance action reduced to Minor for Outcome 16 No additional risk summit required Investment in nursing (£4 Million) agreed at Dec'13 Trust Board External reviews noting 'Keogh' actions in practice e.g. Care and Comfort mentioned in Junior Drs report Positive assurance from recent Keogh Review 23 groups of action- 6 recored as assured and 17 partially assured. No areas recored as not assured	31st October 2013	Implementation of all actions are not complete, outcomes are not yet evident or it is too early to tell if the changes are embedded and sustainable	4	3	12	Implementation of new nursing establishments and skill mix Continue to implement and monitor the delivery of the CQC & Keogh action plans	Executive Director of Nursing CEO	March 2016 May 2014	Amber
	2.4	Failure to implement preventative measures resulting in a serious, largely preventable safety incident (never event)	Inadequate systems and processes to prevent the incident from happening. Immature patient safety culture	Severe harm/death to our patients. Failure to instill confidence in our patients and general public. Potential regulatory action.	Executive Director of Nursing & Executive Medical Director	5	3	15	Stronger focus on patient safety within the Trust. Guidelines and procedures. Duty of candour emphasised. Communication of never events list. Patient safety fellow with an expanding patient safety programme of work.	Previous good record of not having never events. CNST level 2 NHSLA Level 1 Open relationship with CCG's Comprehensive programme of risk management training.	31/10/2014	Implementation of new nursing establishments to increase workforce number. Developing quality governance framework Sustained and embedded governance systems and processes including risk management training.	5	2	10	Implementation of the quality of safety strategy. Continue to implement risk management training.	Executive Director of Nursing.	01/03/2014 December 2014.	

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Strategic Objective 3: Attract, develop and motivate effective teams	3.1	Failure to appropriately manage and train staff to carry out their work.	Managers and supervisors not sufficiently skilled to lead and appraise their teams. Insufficient training opportunities and poor attendance at those opportunities that are presented. Appraisals not being undertaken compliance rate currently 78.27% of a target of 79% Whilst appraisals have been completed the quality of the appraisal may not be seen to support and develop staff.	Increased sickness absence. Poor staff experience outcomes in the staff survey. Staff unclear about what is expected and required of them. Poor quality patient care. Increased patient and staff health and safety incidents. If the Trust cannot deliver contracted activity this may lead to financial penalties from the Commissioners.	Executive Director of Human Resources	4	3	12	Procedures and policies have been revised and updated in respect of training, sickness absence, appraisals and recruitment Additional central resources have been recruited to progress and implement sickness Management Policies and also Staff Appraisal Procedures. New performance management framework has been implemented. Sickness absence panel to more effectively performance manage sick absence to audit return to work interviews.	Quarterly Board reports covering sickness absence, staff appraisals and training. Monthly Board reports highlighting performance with sickness absence, appraisal completion rates and fixed and variable pay expenditure Staff and patient surveys Sickness absence and appraisal reports and actions to Finance and Performance Committee. Workforce and Training Education Committee reports	31/03/2014	Gap in Board knowledge in relation to the effectiveness of the arrangements that are in place.	4	3	12	Action required to assess the effectiveness of the new arrangements including: embedding into objectives of Managers, holding managers to account, improving appraisal completion rates, improving information and data provided. Develop robust process for assessing quality of appraisals	Executive Director of Human Resources	31/03/2014	
	3.2	Failure to attract appropriately skilled staff	Lack of appropriately skilled staff in the labour market both within the UK and Nationally. Poor reputation of the Trust given significant negative media.	Poor quality patient care Increased patient and staff health and safety incidents. Increased variable pay expenditure due to reliance on agency staff.	Executive Director of Human Resources	5	4	20	Procured external companies to assist with international recruitment, (Medical and Nursing). Framework in place to managing the media to ensure good news gets into the press to attract high quality staff to the Trust.	Quarterly Board reports covering staff in post and vacancy rates by staff groups. Monthly Board reports highlighting fixed and variable pay expenditure against plan. Staff and patient surveys	31/03/2014		5	4	20	Appointment of Project Manager to assist with the enhancement of the in-house bank. Review of perception support for nurses. Develop effective in-house bank to increase nursing supply. Review staffing skill mix for medical staff in hard to fill specialties.	Executive Director of Human Resources	31/03/2014	

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	3.3	High levels of clinical posts filled using temporary staff resulting in a financial and quality risk. Increased costs of agency spend and risk of temporary staff not trained/inducted appropriately to area of work Senior and key clinical posts filled using temporary staff	Permanent workforce insufficient to meet business needs. Insufficient staff having appropriate skills and knowledge to deliver required services. Insufficient appropriately skilled and qualified staff in the labour market.	Increased reliance on temporary staff affecting the cost and quality of services delivered	Director of Operations	4	4	16	New and innovative approaches to recruitment process including the use of Trust Open Days. Utilising existing partnership arrangements to fill "hard to recruit" posts; Extending nursing roles to cover medical staff; 2013/14 establishments have been set at 2012/13 outturn results; Invested in strengthening the Nurse Bank; Use of Agency and Bank Staff to cover Band 2 posts is prohibited from June 2013; Procured arrangements for international recruitment, alternative ways of working being fully utilised to ensure safety.	Heatmap reporting to Clinical Governance and Quality Committee is used to flag recruitment hotspots and drive corrective action; Financial and HR reports to Trust Board highlighting cost and use of temporary staff Monthly board Reports highlighting vacancies	31/10/2013	Hard to recruit posts have not yet been fully identified; The recruitment "market place" has not been defined - ie the Trust has not determined where is the post lucrative place to recruit staff nor the best way to attract those staff to the organisation.	4	4	16	Need to assess the success of actions taken to date in reducing reliance on temporary staff; At the same time we need to ensure that current momentum in this area is maintained and that complacency does not set in where we have been successful in reducing the use of temporary staff; We need to develop radically different workforce models to inform our Workforce Strategy and Planning Work, linked to clinical strategies and to form a key element in our business planning processes going forward.	Director of Operations; Executive Director of Nursing and Quality; Executive Director of Human Resources	31/10/2013	
	3.4	Failure to deliver strategic objectives.	Instability at the Board level due to the high level of turnover and interim appointments. Weakened governance arrangements results in failure to drive improvements in patient care. Lack of consistency in Board oversight results in failure to identify and address emerging clinical, operational and financial issues	Lack of continuity leads to reduction in the quality of services and patient care with increased costs.	Chief Executive	4	3	12	Interim Board has been replaced with substantive appointments: - 3 x NEDs from 01/05/13; - Director of Operations from 01/06/2013; - Chairman from 10/06/2013 - CEO from 10/06/13; - 2 x NEDs from 01/07/2013 - Director of Corporate Services/Company Secretary from 27/08/2013 - Director of Strategic Planning and Commercial Development from 02/12/2013 - 2 x NEDs from 01/11/13 In addition, a new Interim Medical Director was appointed on 01/10/2013 and the interviews for this substantive position take place during the second week of February 2014. Following this appointment, all Board positions will be substantive.	Formal sub-committee structure is now in place and operational; New Terms of Reference agreed for each of the sub-committees in the structure; Monthly "real-time" reporting to Trust Board by sub-committee chairs with sub-committee minutes the month after; PwC diagnostic on Board Governance successfully delivered and Board assesses progress against the diagnostic in a monthly basis. Exec Team have regular away days to develop and improve team and individual performance	31/12/2013	Induction programme for new NEDs and Chair is required (timetabled for summer 2013); Board Development Programme needed to support the Unitary Board commences January 2014 PwC scored the Board at 4 (down from 13 January 2013) against Monitor's Quality Governance Framework (QGF) in December 2013	3	2	6	Need to deliver the actions required to address the current gaps in assurance;	Chief Executive Chief Executive	30/09/13 31/12/13	

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	3.5	Failure to develop clinicians into effective managers in the Trust - don't have effective clinical leaders to drive appropriate changes	Lack of effective development programme for clinical leaders, lack of clarity of roles and responsibilities	Poor leadership in divisions and clinical services	Director of Human Resources	4	3	12	Clinical Leadership development programme being implemented. Development for senior divisional management teams including CD's. Effective performance management meeting structure in place for each division.	Divisional performance reported monthly to Board			4	3	12	Completion and Evaluation of development programme		31/03/2014
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Strategic Objective 4: Achieve Financial sustainability.	4.1	Failing to find a solution to PFI excess burden	DH disagrees with outcome of methodology or will not fund result of methodology	Deficit trading position continues to escalate	Chief Financial Officer	5	4	20	Monitor License recognises the need to isolate the PFI impact from underlying financial performance; Discretionary reporting requirements have been added to our licence conditions so they are updated monthly Monitor have requested they are updated if the Mid Notts Review outputs does not contribute to the PFI burden.	Monthly reports to Finance and Performance Committee and to the Trust Board. Paper outlining Trust interpretation of the excess PFI burden has been developed, taken through F&P and shared with Monitor; The £18.3m assessment has been built into the annual plan and the monthly discretionary requirement reporting Monthly meetings	October improvement plan submission	The Mid-Nottinghamshire Transformation Review remains at Blueprint level with only high level modelling assumptions. The blueprint vision needs to better articulate how the LHE will contribute to the PFI premium issue (or not)	5	4	20	External review of PFI premium assessment to be undertaken Clarification of modeling assumptions behind Mid Notts blue print.	Chief Financial Officer. Chief Financial Officer.	30/09/13 October re-submission to Board	
	4.2	Insufficient cash liquidity.	Failure to secure sufficient cash financial support in 2013/14.	Insufficient cash available at short notice results in failure to pay staff and suppliers leading to breach of statutory responsibilities and shortfall in availability of essential medical supplies. Failure to maintain going concern status	Chief Financial Officer	5	3	15	Letter from DH to support for 2013/14 Commitment from Monitor for cash support - submission to go to Oct ITFF meeting	Monthly report to Trust Board and Finance and Performance Committee outlining cash position and forecast cash flows; Monitor made aware of the cash position in December 2012 and monthly reports to Monitor during 2013/14 have included cash position analysis and forecast cash flows.	31/12/2013	Commitment to liquidity support for the final quarter of 2013/14 has not yet been received. Liquidity support needs to be aligned with the Trust demonstrating delivery of CIP's.	5	2	10	Obtain commitment to liquidity support for the final quarter of 2013/14. Shape a Trust wide view of our benchmark ambition, taking into account all the existing work already focusing on these performance targets	Chief Financial Officer.	30/11/13	
	4.3	Failure to have an agreed financial improvement plan	Inadequate information on market opportunities and threats. Sub optimal Contract agreement with Commissioners. Planning process insufficiently project managed.	Inability to adequately plan capacity. Insufficient progress on factors the Trust can influence (efficiency agenda) and lack of support for factors the Trust can not influence (excess PFI burden)	Chief Financial Officer	5	4	20	Board strategy approach being shaped to include external inputs re clinical and estates strategies. Mid Notts joint working to better understand impact	Monthly report to Board of Directors. Monthly Monitor returns	31/10/2013	Board strategy not refreshed in time for October improvement plan submission. Investment requirements associated with KEOGH review not yet impacted	5	4	20	Full achievement of CIP programme	Chief Financial Officer	31/10/13	
	4.4	Failure to adequately manage the agreed operational and financial plan	Processes and information are not robust enough at divisional level	Inability and capacity of the organisation to deliver the agreed plan	Chief Financial Officer	5	4	20											

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	4.5	Reduced funding from Commissioners	Further deterioration of the financial health of the local economy. Unforeseen alterations to allocations and/or demand for services exceeds agreed activity plan.	Increased financial gap. Quality of service provision severely challenged. Commissioners seeking further savings from the trust over and above agreed CIPs	Trust Board	5	4	20	PBR based contract. QIA process in place for CIP's.					5	4	20					
	4.6	Failure of delivery of year on year CIPs	Complexity of change means the Trust fails to deliver year on year CIPs in a sustained and transformational way.	Scale of transformation required is beyond existing organisational boundaries. Reduced level of influenceable spend.	Trust Board	5	4	20	Development of longer-term CIP plan which is clinically led. PAS implementation in 2014 to support benefits realisation. Incorporated into Board strategy development for October plan submission.								Understand scale for change programme that is stretching but achievable			October 31st	
	4.7	Lack of financial management across the Trust	Staff within the Trust do not have a thorough awareness/understanding of good financial governance	Expenditure exceeds available financial resource	Trust Board	5	4	20													

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Objective	Risk no.	Risk description		Consequence	Risk owner	Gross impact	Gross likelihood	RAG Status	Existing controls	Sources of assurance	Expiry date	Gaps in assurance	Net impact	Net likelihood	RAG Status	Action for further control	Action owner	Due date	Movement from prior assessment
What is the Trust's objective?	Risk ref	Describe the risk which threatens the achievement of the objective	What might cause the risk to occur?	What are the possible consequences if the risk occurs?	Individual ultimately accountable for managing the risk	Rating of 1 to 5	Rating of 1 to 5	IxL	What existing controls and processes are in place to manage the risk?	What positive assurances are there? What benefits have these brought?	When is the assurance valid until?	What has not yet been done?	Rating of 1 to 5	Rating of 1 to 5	IXL	What further action (if any) is necessary to address the gap?	Who is responsible for this action?	When must it be completed?	Red / Amber / Green
Strategic Objective 5: Communication and engagement channels need to be strengthened with health and social care partners	5.1	Planned restructure of services identified in the Mid Nottinghamshire transformation review.	Poor relationship with other health and social care partners in the Nottinghamshire health economy. Restructure of services not implemented as planned.	Planned savings for the Trust and the local health economy not delivered.	Executive Director of Strategic Planning and Commercial Development	3	3	9	The Trust is a member of the Transformation Board responsible for the delivery of the mid-Nottinghamshire transformation review; The Trust is providing clinical leadership in the development of the mid-Notts transformation review. Contract executive joint meeting. Clinical Services Plan Programme Board.	Monthly reports to the Trust Board; Monthly reports to HMB; Monthly reports to the Newark Strategy Group	30/06/2013	Commissioner timetable has slipped and further slippage will delay the findings and impact assessment on the Trust. Outcome of consultation on findings conclusions and recommendations from the review is also an	3	3	9	Analysis and assessment of impact from the findings, conclusions and recommendations of the Mid-Nottinghamshire Transformation review when it is complete.	Executive Director of Strategic Planning and Commercial Development: supported by lead managers for different organisation	30/10/2013	

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Objective	Risk no.	Risk description	Consequence	Risk owner	Gross impact	Gross likelihood	Existing controls	Sources of assurance	Expiry date	Gaps in assurance	Net impact	Net likelihood	RAG Rating	Action for further control	Action owner	Due date	Movement from prior assessment		
What is the Trust's objective?	Risk ref	Describe the risk which threatens the achievement of the objective	What might cause the risk to occur?	What are the possible consequences if the risk occurs?	Individual ultimately accountable for managing the risk	Rating of 1 to 5	Rating of 1 to 5	What existing controls and processes are in place to manage the risk?	What positive assurances are there? What benefits have these brought?	When is the assurance valid until?	What has not yet been done?	Rating of 1 to 5	Rating of 1 to 5	IxL	What further action (if any) is necessary to address the gap?	Who is responsible for this action?	When must it be completed?	Red / Amber / Green	
	5.2	Clinical strategy does not fully reflect the requirements of commissioners and other stakeholders.	Clinical strategy not updated regularly. Insufficient involvement of stakeholders in setting clinical strategy.	Failure to deliver new and innovative services for patients to fully meet commissioner requirements.	Executive Medical Director	4	3	12	Programme Board Structure and programme of work have been developed. Head of Pathway Development has been appointed. Two streams of work have been implemented to inform the strategy - Theatres and Operations. Service improvement process has been developed.	None	30/06/2013	Healthcare Planners not yet appointed to support the Programme Board and associated programme of work. Newly formed teams that have not worked together before need to come together quickly; Gaps in transformation skills and pathway redesign skills have not yet been quantified; Outcomes of the Mid Nottinghamshire Transformation Review are not yet known and could impact on work programme; Impact on estate has not yet been assessed; Divisional based strategies are currently under development; Positive sources of assurance not yet identified	4	3	12	Action needs to be taken to address the known gaps in assurance as outlined previously.	Director of Operatins, Director of Strategic Planning & Clinical Director	30/09/13	
	5.3	Failure to rectify governance failings and emerge from breach of authorisation		Trust remains in breach of authorisation leading to potential loss of business and take over	CEO	5	4	20	Review of governance across the trust by PwC. Recommendations and action plans reviewed by PMO workbooks and reviewed weekly at Programme Board.	Integrated programme/project workbooks developed and being refined to incorporate QGF and Financial Governance. PwC scored the Trust against Monitor's Quality Governance Framework at 4. (down from 13 January 2013) in December 2013.		4	3	12	Consolidated action plan developed and quality improvement group established. All actions have accountable owners. Quality improvement Group reports to Programme Board monthly.	CEO	30.01.2014		

Impact ratings 1 to 5

- 1 Insignificant
- 2 Minor
- 3 Moderate
- 4 Major
- 5 Extreme

Likelihood ratings 1 to 5

- 1 Rare
- 2 Unlikely
- 3 Possible
- 4 Likely
- 5 Almost certain

Likelihood

X

Consequence

	Insignificant = 1	Minor = 2	Moderate = 3	Major = 4	Catastrophic = 5
Rare - 1	1	2	3	4	5
Unlikely - 2	2	4	6	8	10
Possible - 3	3	6	9	12	15
Likely - 4	4	8	12	16	20
Certain - 5	5	10	15	20	25

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