MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Report of:	Group Executive Director of Workforce & OD
Paper prepared by:	Executive Director Leads Alwyn Hughes (Trust Board Secretary)
Date of paper:	March 2018
Subject:	**MFT Board Assurance Framework (March 2018)**
Purpose of Report:	Indicate which by ✓ • Information to note • Support ✓ • Resolution • Receive
Consideration of Risk against Key Priorities:	In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to receive the latest iteration of the organisation's Board Assurance Framework (BAF) – March 2018
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MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE FRAMEWORK
(March 2018)

1. Purpose

This paper asks the Board of Directors to receive the latest iteration of the Board Assurance Framework (BAF) for the Manchester University NHS Foundation Trust (MFT).

2. Context

A Board Assurance Framework (BAF) is required to allow the Group Board of Directors to have a clear understanding about where it gains its assurances from, and to seek further or additional arrangements where there is insufficient assurance. The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives.

The two former FTs had well developed BAF documents which served as a useful starting point for the development of a new combined BAF presented to the MFT Board of Directors in October 2017.

3. Progress

It is accepted that the BAF for the new organisation will continue to mature over the first 12 months of operation to reflect the further development of the Group Risk Management Framework, and, introduction of the new Assurance Oversight Framework (AOF).

The BAF is a ‘live’ document and ongoing review takes place to inform the agendas of the Group Board of Directors & Group Scrutiny Committees. Further application and refinement of the BAF is also presented to the Trust Audit Committee for consideration (on behalf of the Board of Directors).

4. Recommendation

The Board of Directors is asked to receive the most up-to-date BAF (March 2018) for the Manchester University NHS Foundation Trust (MFT).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK (2017/18)

***** March 2018 *****

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

Severity ↓	Likelihood →				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2: Slight	2 Very Low	4 Very Low	6 low	8 low	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5: Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

1	**Strategic Aim:** To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.

Principal Risk: 1. There is a risk that the process for NMGH to be acquired by MFT could be challenged by a third party.	**Enabling Strategy**	**Associated Committee**
	Single Hospital Service	Board of Directors
	Lead Director	**Operational Lead**
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 3x4	The effect would be to stall or halt the process of acquiring NMGH, with the impact of potentially increasing transaction costs and reduced benefits for patients.	MFT's involvement in the NM Strategy Board and other GM Partnership forums (e.g. Theme 3, SPB, PFB). MFT's membership of the PAHT Transaction Board and associated sub-groups. GMH&SCP and NHS I will oversee the process. MFT has and will continue to take legal advice from Hempsons.	9 3x3	Need to continue to influence the work of the NM Strategy Board and enhance links with commissioners. In addition liaise with the national NHS I team to ensure a firm options statement is issued which limits the risks to MFT.	NHS I has yet to confirm the counterfactual and associated options	Commitment from partners across GM (commissioners and providers) to support the approach set out by NHSI. Further legal advice. SFRT working closely with MFT to ensure both potential acquirers provide a unified position in responding to the definitive statement when issued by NHS I.	Successful track record in acquiring Trafford and the CMFT / UHSM merger. Commitments received to date from GM partners.	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Attendance at NM Strategy Board, NM Master planning sessions. PAHT Transaction Board and associated sub-groups (finance/estates/communications/IM&T)	ngle Hospital Service and Group Director o	Monthly going forward 2018	Board of Directors	MFT is up to date on the process for initiating the acquisition of NMGH and able to influence.	Too early to determine.
Maintain contact with NHSI regional and national teams. Work closely with GMH&SCP in its role as overseeing body for the dissolution of PAHT.	ngle Hospital Service and Group Director o	Monthly going forward 2018	Board of Directors	MFT is up to date on the process for initiating the acquisition of NMGH and able to influence.	Too early to determine.

Principal Risk: 2. There is a risk that it will not be possible to access the resource needed to manage the process of acquiring NMGH.	**Enabling Strategy**	**Associated Committee**
	Single Hospital Service	Board of Directors
	Lead Director	**Operational Lead**
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
9 3x3	The process of acquisition may not be well managed, leading to delays or a rejection of MFT's business case for the acquisition of NMGH.	Additional resource identified to support the programme management of the NMGH acquisition process. SHS Team working closely with existing management teams.	6 3x2	None	GMH&SC P /NHS I need to accelerate the development of project / programme plan and reporting structures for the dissolution of PAHT. MFT to play its full part in the construction of the plan as it affects the acquisition of NMGH.	Develop acquisition project / programme plan with milestones and reporting structures. Achievement of milestones in programme plan	Track record and experience gained from the CMFT / UHSM merger.	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Develop detailed NMGH acquisition project plan and milestones	Director Single Hospital Service	Feb-18	Board of Directors	Clear milestones agreed and tasks / actions in place to deliver.	Work underway led by GMH&SCP /NHSI with a view to completing the programme plan by February 2018.

Principal Risk: 3. There is a risk that decisions about NMGH service provision taken by Commissioners and the Northern Care Alliance in the run up to acquisition could complicate the transaction process.			Enabling Strategy: Single Hospital Service			Associated Committee: Board of Directors	
			Lead Director: Director Single Hospital Service			Operational Lead: Director Single Hospital Service	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
9 3x3	The effect would be potentially to fragment or destabilise services and reduce the potential Single Hospital Service benefits of acquiring NMGH .	MFT's involvement in the NM Strategy Board. NM Master planning subcommittee and other GM Partnership forums (e.g. Theme 3, SPB, PFB). Also membership of the PAHT Transaction Board and sub-groups. Stocktake of existing NMGH services that has been carried out MFT service strategy development programme takes account of NMGH services MFT / MHCC working relationship	6 3x2	Northern Care Alliance is currently managing services at NMGH and working with Commissioners to make decisions about service provision on the NMGH site. Decisions about NMGH are not totally within the control of MFT	Lack of visibility of changes being made at service level if these are not communicated at NM Strategy Board or through the PAHT Transaction Board Commissioning sub-group.	Feedback from clinical teams at MFT and PAHT, providing routes to communicate any service changes to MFT corporate level if needed. PAHT Transaction Board commissioning sub-group assessment and control of any changes proposed at NMGH. In addition the introduction of a business as usual protocol between MFT and NCA accompanied by a formal MOU.	Agreements that services should remain fixed at their April 2017 configurations	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Strengthen intelligence by building links with NMGH clinical community and wider stakeholders. Continue to build working relationships with MHCC with regard to NMGH.	Director Single Hospital Service	January 2018 and on-going	Board of Directors	Better information on which to build challenges to any proposed services changes at NMGH.	Too early to determine.

Principal Risk: 4. There is a risk that the proposed transaction could create uncertainty amongst staff at NMGH and this could exacerbate recruitment and retention difficulties.			Enabling Strategy: Single Hospital Service			Associated Committee: Board of Directors	
			Lead Director: Director Single Hospital Service			Operational Lead: Director Single Hospital Service	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	If recruitment and retention difficulties are exacerbated this would mean that MFT would acquire an organisation with significant staff shortages.	MFT and the Northern Care Alliance (NCA) both recognise the issue and will work together to mitigate the risk. As a first step joint recruitment activity across MFT and NMGH for consultant medical staff in hard-to-fill services has already commenced and will continue. Communications and engagement work with NMGH staff has been ongoing since Project One and will continue for the duration of Project Two. Partnership arrangements (e.g. staff side) are currently being reviewed to take account of NMGH requirements.	16 4x4	Greater Manchester Health and Social Care Partnership (GMHSCP) has over-arching responsibility for communications about the dissolution of PAHT (two transactions) therefore MFT does not have complete control over the content or timing of communications messages. In addition, communications need to be agreed across multiple partners which can cause delays. GMHSCP also has responsibility for producing the overall project plan which will inform much of the communication and engagement activity.	Project Plan has not yet finalised by GMHSCP led PAHT Transaction Board and this is hindering communications and engagement activity. Strategy and protocol for communications and engagement with NMGH is yet to be agreed.	Creation of a tri-partite workforce partnership forum with trade unions, MFT and NCA. Promotion of NMGH/MFT as an attractive place to work and learn.	Completion of the transaction Project Plan to inform communication and engagement activity with NMGH staff. Completion of a transaction communications plan signed-off by all parties.	12 4X3

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continue to engage effectively with GMHSCP and other partners in the transaction to influence key decisions. Establish and strengthen relationships with trade unions and NCA..	Director Single Hospital Service	January 2018 and ongoing.	Board of Directors	Solid information about the transaction to convey to NMGH staff and agreed mechanisms for communication and engagement.	Too early to determine.

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

Principal Risk: If the organisation does not achieve A&E / Urgent Care Waiting Times Then this could impact on clinical outcomes and patient experience (5006C)	Enabling Strategy	Associated Committee
	Transformation Programme	Transformation Programme Board
	Lead Director	Operational Lead
	Chief Operating Officer	Director of Performance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact /Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 4x5	Clinical Outcomes	Hospital Site operational/performance oversight meetings. GM Urgent Care Board and reform plan Manchester Urgent Care Transformation Board and supporting ODGs. LHE OPEL escalation and teleconferences NHSI oversight Daily SITREP reporting Performance and operational reports in place to support the standard and patient flow Escalation and site management processes/policy On call arrangements Daily information sent to the GM Urgent Care Hub to support system management Trust Accountability and Oversight Framework	20 4x5	Workforce Demand levels in excess of planned levels Mobilisation of GM winter resilience schemes to reduce demand Mobilisation of OPEL across the economy Reliance on partners and external capacity to enable timely discharge and reduction of DToCs	Factors which can cause significant and sustained surges in demand	Performance reporting to Board of Directors.	Risk Management Committee. Quality and Performance Scrutiny Committee. Board of Directors	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Al Hospitals have in place a winter plan, supplemented by Christmas plans Secured winter resilience funding and implementation of schemes Secured additional Budget funding to open 41 additional escalation beds at MRI, Mobilised earlier than planned due to post Christmas pressures. Cancellation of elective activity in Q4. Use of daycase areas for short stay medical patients in January 18 Increased GP access to AMU at MRI Flu management processes. Trust Transformation programme Implement Trust activity and capacity plans Capital upgrade to MRI/Wythenshawe EDs Implementation of GM standards for patient choice, trusted assessor and Discharge to Assess. Participation in GM Action on A&E events. Trust will be part of cohort 1 of the Surgical Ambulatory Emergency Care Network. MRI Perfect week to be held on 14-22 March	Clinical Divisions / Health System	on-going	Quality & Performance Scrutiny Board of Directors	Improved Patient Flow / Greater Seasonal resilience	Central/TGH and Wythenshawe Hospitals have had strong performance against STF trajectories in Q1 and Q2, and are top performers in GM. Underperformance against the STF threshold in Q3 with performance of 87.44% Q4 (as at 27/02/18) 85.88% Central/TGH have continuously delivered the GM DToC standard of 3.3%. However, performance at Wythenshawe site has been more challenged at circa 7%, although significantly improved compared to the same period the previous year.

Principal Risk: If mortality rates are not below 100 before rebasing then this may indicate poor quality outcomes and will impact negatively on organisational reputation (2848C)			Enabling Strategy			Associated Committee		
			Mortality Review Strategy			Mortality Review Group		
			Lead Director			Operational Lead		
			Medical Directors			Associate Medical Director / Director of Clinical Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
20 4x5	Poor patient outcomes Reputational impact Associated business continuity	Hospital/MCS Structure CD Programme and leadership development Standards of clinical care Pathways in place NICE/NCEPOD monitoring High Level Investigation thematic reviews Mortality Review Groups in place - Group arrangements being clarified Coding differences betweeen the larger sites under review and being standardised Revalidation and appraisal process Patient safety projects Clinical audit processes Structured Judgement Review training undertaken	**12** **4x3**	Coding inaccuracies Adherence to record keeping standards Gaps in compliance with new National guidance	Lack of confidence in accuracy of coding information	Intelligent Board Framework Mortality dashboard Benchmarking using NHSIC data Further clinical audits on pathways Health Education North West visit data Internal Audit Central Portal GMC survey data Monthly CQC feedback Full evaluation of Leadership schemes	Aqua Regional Report on Mortality Current Group SHMI and HSMR ≤100	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Development of a joint work programme by the Clinical Governance Team the Informatics Team and the OD&T Team on the quality of the patient record. See risk 2848 for detailed action. Work underway to meet the requirements of the new National guidance. Standardisation of approach across the Group - use of the structured judgement review	Bronwyn Kerr - Associate Medical Director Sarah Corcoran - Director of Clinical Governance Alison Daily - Director of Informatics	2018	Quality and Safety Committee	SHMI <100 HSMR <100	SHMI ≤100 HSMR ≤100

Principal Risk: If the organisation does not have the capacity to meet the Diagnostics 6 Week Target this could impact on clinical outcomes, patient experience and performance targets (4535C)			Enabling Strategy			Associated Committee		
			Transformation Programme			Transformation Programme Board		
			Lead Director			Operational Lead		
			Chief Operating Officer			Director of Performance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact /Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	Hospital site operational and performance management meetings. Corporate Performance and Delivery Assurance Group Recovery trajectories refreshed in January 2018 Monthly forecasting in place for all sites Trust Accountability and Oversight Framework	16 4x4	Demand in excess of planned levels National cancer campaigns Patient Choice failures in equipment Workforce pressures	Reliance on private sector GM capacity constraints across a number of providers	Performance reporting to Quality and Performance Scrutiny Committee and Board of Directors.	Risk Management Committee. Quality and performance Scrutiny committee. Board of Directors	**12** **4x3**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Recovery trajectories refreshed in January 2018, actions have been in place throughout 2017/18. Adult endoscopy - 3rd party provider in place. Long term workforce plan with recruitment in progress. Capital work to support JAG accreditation completed in December and new unit at the MRI site opened. RMCH endoscopy - long term workforce plan in place, 2 substantive consultants recruited commencing in post in July and November. Additional sessions being undertaken to reduce the backlog. Paediatric MR - additional anaesthetic sessions secured from the end of August onwards, however demand has increase in excess of these levels and therefore further options being explored. Central non-obstetric ultrasound - reallocation of the workforce and additional sessions. Wythenshawe non-obstetric ultrasound - use of additional sessions and the development of long term workforce plans. Business case for the 3rd MRI scanner approved Participation in GM Task ad Finish group focused on diagnostics.	Clinical Services	Improvement expected in Q4 and into 2018/19	Quality and Performance Scrutiny Committee	Waiting times delivered	Central/TGH sites - significant improvement in the performance compared to January 2017. Wythenshawe - historical strong achievement of the standards, performance deteriorated in the summer due to workforce pressures in non-obstetric ultrasound but the site has since recovered and sustained performance below the standard. Performance: 2.5% Oct, 2.23% Nov, 2.48% Dec, 3.27% Jan. A slight increase in the performance in January due to administrative pressures within Echocardiogram and the requirement for General Anaesthetics for specialist cases.

Principal Risk: If the organisation does not achieve Cancer Waiting Time Targets, Improve Patient Experience & Clinical Outcomes (5143)			Enabling Strategy: Performance Management Lead Director: Chief Operating Officer			Associated Committee: Quality & Performance Scrutiny Operational Lead: Director of Performance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 **4x4**	Clinical Outcomes	Hospital site performance management meetings. Trust Cancer Committee. Performance reporting in place Cancer site PTL meetings and management of patients through the pathway. RCAs undertaken for all breach patients Harm reviews undertaken for any patient +104 days on a pathway Escalation process in place to ensure timely action of patients along the pathway. GM Cancer Access Policy updated and signed off by NHSI in January 2018, and subsequently presented to Trust Cancer Board Trust Capacity Group to receive risk assessment/capacity plans for national cancer campaigns to mitigate demand increases. Cancer peer review undertaken on an annual basis Trust Accountability and Oversight Framework	**16** **4x4**	1. Pathway management across multiple Trusts. 2. Patient choice 3. Demand in excess of planned levels 4, Critical care constraints affecting elective activity 5. Diagnostic capacity pressures impacts on pathways	Adherence to GM developed cancer pathways Surges in cancer demand, 17% increase in Q1 2017	Performance reporting to Board of Directors. Oversight of performance delivery at the Trust Cancer Committee chaired by the COO Performance oversight through the Trust Performance and Delivery Assurance Group.	Risk Management Committee. Quality and performance committee. Cancer Board	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Escalation of pathway stages continues. Weekly monitoring of individual patients that are +30 days on the PTLs Escalated performance management arrangements in place Cancer site level action plans - focused on increasing capacity for first appointment, diagnostic scanning and reporting and surgical capacity in Urology. Cancer site pathways - lung working to implement optimum pathway, LGI diagnostic pilot COO has met with high risk cancer sites. Trust compliant with the 10 High Impact Actions for Cancer, and has reviewed national best practice ensuring this is taken into consideration within the Trust action plan Capacity and demand work being undertaken across pathways to increase the number of 2ww patients seen within 7 days.	Clinical Divisions, Corporate Performance Team	End of 2017/18	Cancer Committee	Delivery of Cancer Standards	Continued growth in cancer demand Wythenshawe site continue to have strong performance against the 62 day standard. Central/TGH sites are challenged with performance at circa 79% Q3 performance at 84.3%

Principal Risk to Key Priority:	Failure to deliver the Medical Workforce Projects	Enabling Strategy		Associated Committee	
				HR Scrutiny Committee	
		Lead Director		Operational Lead	
		Robert Pearson		Jill Alexander	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 4x3	Failure to deliver the Medical Workforce projects could lead to patient safety risks associated with inability to fill medical shifts, loss of control of agency and internal locum spend, and impact on Turnaround	1.Group Executive Sponsors of Medical Workforce Workstream 2. Hospital management teams 3. Accountability Oversight Framework (AOF) 4. Job Planning Tool implementation and outputs 5. 7DS Group and 7DS RAG-rated Action Plan 6. 7DS Joint Assurance Group (Central and Wythenshawe) 7. HR Scrutiny Committee oversight 8. Finance Scrutiny Committee oversight 9. LNC liaison 10. Turnaround Committee 11. Medical Staffing Costs monthly dashboard 12. Internal Locum Dashboard (eWIP) 13. Top Earners (Additional Shifts) Report 14. WAVE monitoring 15. NHS I Weekly Agency Report 16. Trackers to underpin locum and agency use within the Divisions 17. MIAA Audit Recommendations	12 4x3	Consistency in approach of Hospitals/ Divisions Consistency in approach at regional and national level (Different levels of engagement displayed by Hospitals/ Divisions) Consistency around key Medical Workforce processes (e.g. Annual Leave, Agency approval process) Differing approaches to management and reduction of locum and agency spend across Hospitals/ Divisions Gaps in the workforce information recorded and monitored by Hospitals/ Divisions;and lack of tools to effectively manage available workforce information No prompts in the paper patient record - EPR would resolve this (7DS) Transition to new Hospital Management Structures and dissolution of MWP Team	Assurance that key information is cascaded appropriately within Hospitals/ Divisions (e.g. from Senior Management Teams down) Robustness of Job Planning Tool and ensuing reports Difficult to qualify/ quantify impact of Medical Workforce projects on Turnaround MWP Team will cease to exist in its current format	CEO Forum reports Regular updates to Joint Group Medical Director and Group Director of Workforce and OD HR Scrutiny Committee progress reports NHSE Monitoring Reports Turnaround Control Group	Steady progress to 100% Consultant Job Plans available via Job Planning tool and evidence of annual review Reducing Locum/ Agency Spend Visible improvement in each 7DS Self Assessment Survey cycle (currently Spring) Tangible progress/ completion against recommendations set out in the MIAA Audit of Locum and Agency Staff	6 3x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Update
On-going Actions from August and October BAF Documents					
Provide training (Job Planning Tool; Team Job Planning)	Alison Wake, Ash Sukthankar	Q1	- CEO Forum - HR Scrutiny Committee - Turnaround Control Group - Quality and Performance Scrutiny Committee - Board of Directors - GMB - Operational Workforce Committee	All Consultant Job Plans are input to the Job Plan tool; and approved Divisions are engaged in Team Job Planning; and can use reports produced by the Job Plan tool to inform changes and improvements for the next job planning cycle	96% Job Plans effective 17/18 have been approved (excluding any agreed as 'on hold'). Job planning cycle for Job Plans effective 18/19 has begun, with Divisions undertaking Team Job Plan meetings prior to agreeing changes to individual job plans. A number of Team Job Plan training sessions have been successfully run on the Central site; similar sessions have now been offered to South sites, to be arranged.
Provide regular job plan status reports to Divisions	Cameron Chandler	On-going		Divisions are well-informed regarding the progress of input and approval of Job Plans	A new report has been developed to reflect the status of individual job plans for 18/19; and the progress of Team Job Planning within the Hospitals/ Divisions. These new reports will be circulated from February 2018.
Coordinate MIAA audit of processes for booking locum medical staff; and work with Divisions to standardise processes and implement recommendations from this audit	(Jill Alexander)	Q2/3		Reduction in locum and agency spend following the introduction of improved processes and/or replication of areas of good practice Trust-wide	MIAA Report forwarded to MRI RMCH is considering a further 'deep dive' audit with MIAA.
7DS Autumn Survey (September)	Divisions, supported by Cameron Chandler	Q2		Improvement in Trust-wide and individual Division results from the Spring Survey	The Autumn 7DS Survey ran from 20th to 26th September. The Trust was only required to audit against Clinical Standard 2 - Time to first Consultant review for this survey. There was an overall improvement from the last survey (from 69% in Spring 2017 to 74% in Autumn 2017); however there is still considerable work to be done in order to achieve the target for this Standard (90%).
Review Allocate products for Job Planning; Appraisal; and Medics' rostering: - Demonstrations of products - Commercial considerations (e.g. procurement, costs, SHS) - Development of Business Case	MWP Team	Q2		A robust Business Case is developed to support the introduction of a suite of tools that will provide a more detailed understanding of the medical workforce, enabling better management of this resource	Business Case Approved 26.02.18
Work with Divisions to begin the next cycle of Job Planning; and monitor progress	MWP Team	Q2/3		Divisions use Team Job Planning to update existing Job Plans and approve all Job Plans by close of 2018/19	Hospitals/ Divisions have been sent generic WAVE milestones in line with national job planning guidance as part of their Turnaround Opportunity Pack for Medical Workforce. These milestones have been discussed with Hospitals/ Divisions at their January meetings with the MWP Teams.
Support Divisions to identify persistent gaps in Junior Doctor Posts	MWP Team	Q3		Divisions are able to understand any recurrent or persistent gaps in staffing, and identify the best means of addressing these gaps (e.g. re-modelling, making posts more attractive through rotations etc)	All Hospitals/ Divisions have submitted an update on Junior Doctor gaps for Q3; this information is to be maintained on a quarterly basis going forward.
Work with Divisions to establish Local Consistency Panels for Job Plans	MWP Team	Q3		Each Division has a Local Consistency Panel that is able to resolve discrepancies and locally mediate any disputed job plans	In implementation with corporate guidance documentation
Create Transition/ Handover Pack for Hospitals/ Divisions	MWP Team	Q4		Hospitals/ Divisions are well positioned to pick up the Medical Workforce agenda, and have clarity regarding the escalation and Group assurance routes	Completed 27.02.18
Handover meeting with the Medical Workforce Workstream Executive Sponsors	All Hospitals/ Divisions; MWP Team	Q4		Hospitals/ Divisions outline how they will pick up the Medical Workforce workstream agenda, and provide assurances to the Group Executive Sponsors of their commitment to deliver this workstream	Completed 27.02.18

Principal Risk: If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised			Enabling Strategy: Nursing and Midwifery Retention Strategy and Recruitment Work Programme Lead Director: Chief Nurse			Associated Committee: Nursing and Midwifery Professional Forum and Human Resources Scrutiny Committee Operational Lead: Director of Nursing		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4		1. Nursing & Midwifery Professional Forum, Clinical Risk Management Committee and HR Scrutiny committee monitor controls in place 2. Domestic recruitment 'proud to care' campaign continues to attract applicants. 3. Candidate engagement processes established to maintain candidate interest in role from application to commencing in post. 4. Regular reports from recruitment management system to identify delays in process and enable actions to be taken 5. Programme of international recruitment from EU and India is in place 6. Nursing and Midwifery retention strategy 7. Monthly ESR reports established to monitor turnover and new starter activity 8. Acuity and dependency monitoring undertaken in all areas where validated tool is available 9. Developed reporting mechanism from e rostering and safe care system to enable effective management of resource in line with patient acuity 10. Implemented revised nursing and midwifery workforce reporting processes aligned with finance and workforce planning data 11. Board support to recruit to turnover for band 5 and band 2 roles within the Trust 12. Analysis of integrated governance information such as complaints and incidents against staffing levels	**9** **3x3**	Current recruitment process provides limited assessment for values and behaviours Embedding use of E roster and safe care in real time within all clinical areas. Brexit and regulatory changes to English language requirements have seen a marked decline in the number of EU nurses applying to work in the UK which has an impact on supply	Ability to reduce number of vacancies against the national workforce supply issues in terms of qualified nurses and midwives.	Recruitment campaigns result in substantive appointments of both nurses and midwives Unify data reported from Heath Roster to ensure accuracy of planned and actual staffing data On target for progress against recruitment plans monitored through nursing and midwifery recruitment meeting. Regular reports from recruitment management system to identify delays in process and enable actions to be taken Reduced turnover and improved retention rate in band 5 roles Time to fill reporting by recruitment phase to support continuous improvement cycle Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) since July 2017 E Rostering and Safe care module used effectively by all wards and departments Control and challenge meetings implemented in all areas to ensure effective rostering of staff Development of new roles to support nursing workforce - housekeeper, ward assistant. theatre scrub assistant-ward pharmacy technician Programme of work in partnership with HR to reduce nursing and midwifery absence rates	Bi annual Safer Staffing reports to Board of Directors. Regular staffing position reports to Trust Group Management Board, HR Scrutiny Committee, Risk Management Committee, and Nursing and Midwifery Professional Forum Establishments reviewed as part of annual budget setting process or when any significant changes in service or patient cohort Acuity and dependency monitoring undertaken in all areas where validated tool is available Recruitment and retention schemes have resulted in reduction in vacancy rate for band 5 roles from 18% (July 2017) to 15.6% (January 2018). There has been an overall increase from July - January 2018 to the nursing and midwifery establishments of 129.67 post SHS merger due to readjustment of financial ledger and development in services. It is predicted that the vacancy rate will increase slightly in Q1-2 whilst waiting staff to complete programmes of training There are 90 wte nurses and midwives currently with conditional jobs offer due to commence in trust before March 2018. There are 220 student nurse and midwives progressing through recruitment checks who will commence in post when graduating in September 2018 Improved retention rate of band 5 staff nurses and midwives over last 12 months to 86.2% . The annual Trust turnover rate for nursing and midwifery is 14.8% (Shelford average 13.8%) Recruitment Retention Strategy to be developed in partnership with HR and through trust wide engagement to reflect needs of new organisation The Trust is part of GM pilot for trainee nursing associate roles with 84 TNAs in training. recruitment is underway to appoint a further 150 candidates to commence training in April and September 2018. The Trust continues to source nurses from overseas (India) through targeted overseas recruitment campaigns. Monthly SKYPE recruitment also takes place to recruit nurses from India and UAE. This programme of work will continue in 2018/19. There have been 51 nurses commenced in post since April 2017 bringing the total to 182 overseas nurses recruited in the last 2 years. Divisional sickness/absence reduction	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
See actions detailed in Trust Risk Management Report (risk 4117C) Revision of nursing and midwifery recruitment plans and retention strategy.	Nursing and Midwifery Workforce Development Group	Sep-18	Nursing and Midwifery Professional Forum	Programme of work continue in line with the actions detail in the retention strategy. Programme of recruitment events agreed for next 9 months to support attraction of staff.	

Principal Risk: If the organisation does not achieve all Referral To Treatment RTT Targets this could impact negatively on patient outcomes and experience (Risk 1858C)	Enabling Strategy	Associated Committee
	Performance Management	Quality & Performance Scrutiny
	Lead Director	Operational Lead
	Chief Operating Officer	Director of Performance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 4x3	Clinical Outcomes	Hospital site performance management meetings. RTT governance structure - RTT Operational Group and Performance and Delivery Assurance Group Data quality programme in place to ensure timely validation and quality of data. All Divisions have a data quality action plan in place. Audit of trust data undertaken by the internal audit team MIAA Information reports in place to support management actions. Corporate and Divisional oversight and management of long waits to prevent any +52 week waits. Wythenshawe recovery trajectory in place Commissioner support in place at Wythenshawe Activity and capacity plans in place Trust transformation programme Trust Accountability and Oversight Framework	16 4x4	Commissioner decisions around alternate providers Impact of winter pressures National recommendation to reduce elective activity throughout January	Robustness and quality of commissioned alternatives	Performance reporting to Board of Directors. RTT Operational Group in place Trust Performance and Delivery Assurance Group	Risk Management Committee. Quality and performance Scrutiny Committee.	12 3x4

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Delivery of Elective Plans for 2017/18 Continued timely validation by Hospital Sites Monthly data quality audits are on-going. External audit on data quality to be undertaken in 2018/19. Delivery of Divisional transformation and capacity plans. Hospital Site performance meetings continue to ensure the effective management of waiting times. Development of a single Patient Access Policy for MFT to be implemented from April 2018 Participation in GM master classes for RTT Participation in NHSI Demand and Capacity modelling training Development of activity plans for 2018/19 Through AOF meetings COO requested trajectories for underperforming areas and are currently being developed for MRI/RMCH	Hospital Sites	On-going	Quality & Performance Scrutiny	Activity Levels Delivered and Waiting times improve	Both the Wythenshawe and Central sites are underachieving the standard. Performance in December and January affected by winter pressures/Flu and the cancellation of elective activity as per the recommendation of the National Emergency Pressures Panel. December performance 89.99%, January 89.98% There is improvement against the standard and in January Wythenshawe performance increased, furthermore RMCH achieved its highest performance of the year against the standard. +52 week waits have been reported to the Board of Directors these are occurring due to a specialist breast procedure at the Wythenshawe site, who is only 1 of 4 centres nationally that provide this procedure, work is ongoing with Commissioners to determine actions and recovery trajectory.

Principal Risk: If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm			Enabling Strategy: Safeguarding annual plan			Associated Committee: Safeguarding Committee		
			Lead Director: Chief Nurse			Operational Lead: Group Deputy Chief Nurse		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 5x3	Adults and children adults at risk of abuse or neglect may come to harm	1. Safeguarding Governance Structures in place and maintained pending integration. 2. Safeguarding policies and procedures. 3. Safeguarding Teams actively support staff. 4.Safeguarding lead Director oversees delivery and monitoring of annual safeguarding work programme 5. Senior representation at MSCB and MSAB and underpinning Leadership/Executive Groups to support statutory duty to cooperate 6. Safeguarding adults and children's training programme in place and updated yearly as per Intercollegiate guidance to ensure up to date and relevant information is contained to ensure staff have contemporary safeguarding information to support practice. 7. Learning Disability flag in place to alert LD Specialist Nurse to review patient. 8. Hospital/Divisional assurance processes to assess compliance with CQC requirements. 9. Incident reporting of non attendance by Trust staff at statutory child protection meetings in place. 10. Policies contain the most up to date information and guidance for the Trust to follow to ensure patients and clients at risk of abuse and neglectare protected. 11. Reports provided to statutory meetings if staff are unable to attend. 12. Child Protection Information Sharing System in place to alert Local Authorities to a child's ED attendance	**10** **5x2**	1. Delays in Best Interest assessment and DoLS authorisation by Local Authority due to insufficient capacity to respond to high number of DoLS applications. 2. Inconsistent quality of MCA assessment and DoLS applications. 3. Not all hospitals achieve full compliance with required training attendance 4. Limited LD specialist nurse capacity and no provision to cover leave.	1. OLM report does not provide detail of training attendance at a level to assure that a individual has undertaken training relevant to their role . 2. Invitations to case conferences and strategy meetings are not received at a single point therefore there is no single monitoring system for the Trust. 3. Seperate service provision and activity recording across Wythenshawe and Central/Trafford sites.	1. Incident Data. 2.Training attendance data demonstrates compliance with level 1 children's safeguarding training. 3. Divisional Assurance assessments 4. DoLS/MCA Assessment Records. 5. Annual Audit Programme Outcomes. 6. External Review (Ofsted/CQC inspection, Section 11 Audit, CCG review of safeguarding and LAC provision) 7. Case conference/strategy meeting attendance records 8. Post Transastion Integration Plan to integrate safeguarding function.	1. Annual Safeguarding Report to Board of Directors. 2. Service work plans - monitored by the Trust Safeguarding Group. 3. Divisional Safeguarding Assurance meetings (Central and Trafford site) re: compliance with CQC regulations with NED with safeguarding lead, Safeguarding Lead Director/Deputy and Head of Safeguarding - reported to the Safeguarding Committee 4. Assessment of complaince and collation of evidence by Wythenshawe Head of Nursing - Safeguarding 5. Completion of SCR actions - reported to the Trust Safeguarding Group 6. Local Safeguarding Board Section 11 audit - reported to the Safeguarding Committee. 7. Annual Safeguarding Work Programme, monitored by Trust Safeguarding Group and reported to Safeguarding Committee chaired by Chief Nurse. 8. Submission of MSAB Annual Assurance statement and supporting evidence	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Deliver annual safeguarding work programme	Head of Safeguarding	31/03/2018	Safeguarding Committee	Safeguard people at risk of abuse or neglect	Safeguarding work programme on track. Delays in Best Interest assessment and DoLS authorisation raised at MSAB. Law Commission have made recommendations for a revised DoLS process, which will require legislative changes prior to implementation. Levels 1, 2 and 3 safeguarding training updated and work underway to integrate training programmes across MFT. New FGM training rolled out. New DoLS /MCA training rolled out. Policies updated to reflect new legislation and multi agency strategic plans Divisional Safeguarding Assurance meetings completed for former CMFT services and demonstrate good progress. Positive section 11 Peer review meeting held with MSCB. Safeguarding PTIP on track. Adult annual assurance statement completed and submitted to MSAB with positive feedback. CQC review of safeguarding children and looked after children services in Manchester conducted and report received in January 2018, highlighting many areas of good practice. Ofsed inspection of MCC children's services conducted in October and report published in December 2017 identified good practice across the partnership, including MFT, and rating improved from Inadequate to Requires Improvement.

Principal Risk: If the Group fails to demonstrate and evidence high quality standards consistently in the delivery of care, leadership and use of resources then the organsation may fail to achieve approariate ratings from regulatory bodies (5447C)	Enabling Strategy: Quality and Safety Strategy / OD&T Strategy / Transformation Strategy	Associated Committee: Quality and Safety Committee
	Lead Director: Medical Director / Chief Nurse	Operational Lead: Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Reputational impact Associated business continuity	SHINE Oversight Group Executive Leadership Regulatory Engagement Meetings Organisational Governance Structure Self Assessment Programme Organisational self assessment Policies & Procedures Pathways Values & behaviours Ward accreditation programme	16 4x4	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old Well-led assessment not yet undertaken Use of resources assessment not yet undertaken	Group and Hospital Governance arrangements Board Assurance Framework CQC Insight Report - currently no overall rating available Board of Directors Reports Internal / External Audit Patient and Staff surveys External Visit Data CQC internal monitoring CQC relationship meetings IQP data Clinical quality metrics Accountability Oversight Framework data	CQC Comprehensive Inspection Report Nov 15 and January 16 Quality Review reports 2016 Deanery and GMC training survey	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Review of SHINE Programme and preparation for comprehensive assessment in the next 12 months from October 2017 Timeline in development	Sarah Corcoran	Oct-18	Quality and Safety Committee	Movement to a CQC rating of 'outstanding' or 'good' across all services Compliance / appropriate ratings across all other external regulation	Timeline complete for CQC/NHS I assessments Executive leadership arranagements in place Structure agreed Self-assessment process underway

Principal Risk: If patient care is not delivered to a high level of safety and quality patients could be harmed, staff could be harmed, the organsation could fail to meet regualtory standards and reputation would suffer.	Enabling Strategy: Quality and Safety Strategy / OD&T Strategy / Transformation Strategy	Associated Committee: Quality and Safety Committee
	Lead Director: Medical Director / Chief Nurse	Operational Lead: Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
15 3x5	Poor patient outcomes Poor staff experience Failure to meet regulatory standards on quality and safety Reputational impact Associated business continuity	Organisational Clinical Governance Structure - including specialist functions such as Infection Control, VTE and EPR Board Organisational self assessment Education and Training Integrated Governance System Policies & Procedures Pathways Values & behaviours Ward accreditation programme	**9** **3x3**	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old	Board Assurance Report Accountability Oversight Framework Board of Directors Reports Internal Audit Patient and Staff surveys External Visit Data Internal Quality Review Reports CQC internal monitoring / Insight Reports IQP data Consultant metrics Clinical Audit Data - local and National Peer Review Processes	CQC Comprehensive Inspection Reports Nov 15 and Jan 16 in legacy organisations Quality Review reports 2016 in CMFT Legacy organisaiton Deanery and GMC training survey CQC Insight Reports	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comprehensive programme of work on communication of diagnostic and screening test results (Risk 3305)	Sarah Corcoran/Gill Bell	January 2019	Informatics Strategy Board	10% reduction in harm	See risk register
Comprehenisive programme of work on meeting all infection control standards (Risk 1970)	Andy Dodgeson / Moira Taylor	October 2018	Infection Control Committee		
Comprehensive programme of work on the management and quality of the health record (Risk 5045C/5048C/5300U)	Sarah Corcoran / Alison Dailly	January 2019	Informatics Strategy Board		
Comprehensive programme of work on the care of patients detained under the Mental Health Act in acute care	Sarah Corcoran	March 2018	Quality and Safety Committee		

Principal Risk: Availability and Management of Patient Records Risks 5045C/5048C/5300U			Enabling Strategy				Associated Committee Group Informatics Strategy Board	
			Lead Director Group Executive Director of Finance				Operational Lead Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Patient Harm as a result of inaccessibility of case notes Reputational Damage arising from poor quality data. Inadequate assurance on quality of care. Financial and reputational damage arising out of failure to meet regulatory quality standards such as CQC. Financial damage resulting from inaccurate coding	Best Practice Standards for Records Management in place & achievement of the standard monitored through a suite of KPIs which improve availability at point of need. Improve visibility of electronically captured patient information by providing access through one system.	16 4x4	Best Practice KPIs not fully in place Full EPR not in place. Pace and content of delivery of EPR.	Monitoring of available case notes not in place.	Accurate monitoring and identifying issues in place and reporting to the EPR Programme Board.	Health Records Improvement Programme in place and funded reporting to Digital Enablement Board.	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Funded Chameleon roadmap in place for 2016/17 and 2017/18 in Capital programme with deliverables which improve visibilty of patient information. Pace and content of delivery increased. Implement some electronic forms in EMIS for Children's services to reduce the reliance on paper and therefore storage. Introduction of a trust wide scanning solution which will be available via Chameleon. Introduction of a Trust Wide Unique Patient Identifier. Introduction of one set of case notes for MFT for new registrations. Introduction of terminal digit filing which will stop the annual movement of notes to Restore and allow case notes to be filed at Gorton regardless of how long the patient has been in our care. To change the case note number to automatically created and match the PAS number (district number). Label will then be printed and put on a blank set of case notes. Introduction of bar code labels on new sets of case notes	Director of Digital Delivery	On-going	Informatics Strategy Board	Best Practice Health Records Standards in place.	

Principal Risk: Cyber Security Risk - Trust IT			Enabling Strategy				Associated Committee Group Informatics Strategy Board	
			Lead Director Group Chief Finance Officer				Operational Lead Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	If there are malicious attacks to IT system, vulnerabilities could compromise or disable access to systems and or data. Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm and patient experience adversely impacted (e.g. wait times increased) as well as Financial & reputational damage.	Appropriate Controls are in place to manage the threat of cyber attack and other IT vulnerabilities and security threats.	16 4x4	Reguar reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	Emerging Cyber Risk may mean gap in assurance through non-availbility of specialist knowledge at point of risk.	Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	All agreed actions carried out in line with approved plan timescales.	**12** **4x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Investment in key IT infrastructure to reduce the incidence and impact of cyber risk.	Group Chief Informatics Officer	on -going	Group Informatics Strategy Board	Minimise risk to the Trust.	

3	**Strategic Aim:** To improve the experience of patients, carers and their families

Principal Risk: If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public	**Enabling Strategy**	**Associated Committee**
	Safe operation of the site infrastructure	Estates Strategy Board
	Lead Director	**Operational Lead**
	Chief Operating Officer	Director of Group Estates and facilities

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
15 3x5	Loss of operational area(s) and potential impact for harm to staff, patient of public	Detailed business continuity plans to mitigate the impact of any failure Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system). Agreed maintenance regimes to ensure the infrastructure is maintained to the required level External reviews of systems and processes to highlight gaps and required actions	15 3x5	Not all maintenance regimes have been adhered to and not all infrastructure schematics accurately represent the 'as built' estate Some controls are reactionary, based on minimising impact should an issue occur	Time taken to complete external reviews and surveys & undertake any required remedial works	Ongoing survey and audit reports to reduce level of unquantified risk and support that adequate controls are in place. Expert analysis of risk as developed through Trust and independent experts to confirm the adequacy of the controls	Ongoing certification of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects Focus remains on key clinical areas for remedial actions	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Complete the ongoing survey works across all sites Complete all remedial works across the sites	Director of Estates & Facilities	Jun-19	Estates Strategy Board	Survey work completed & remediation carried out	Survey and remediation work on track with the exception of electrical infrastructure on the Oxford Road site. Further work ongoing with ProjectCo and Sodexo to address this

Principal Risk: If there are insufficient trained mental health support this could impact negatively on patient outcomes and experience (Risk 4140C)	**Enabling Strategy**	**Associated Committee**
	Quality and Safety Strategy	Quality and Safety Committee
	Lead Director	**Operational Lead**
	Medical Director	Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Poor patient outcomes Poor patient experience	Safeguarding Team Policy guidance on the Mental Health Act specifically Guidance on the Mental Capacity Act Training to ensure clincal understanding on quality of care Mental Health Nurses Mental Health Act Manager Staff expertise Specialist recruited to review	**9** **3x3**	Formalised arrangements for Psychiatric Liason support	Lack of qualititative data on services	Clinical audit Patient feedback External review	None	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Working with Greater Manchester Mental Health Foundation Trust and Manchester CCG have formalised arrangements. Support funded and recruited to maintain progress in year Group governance structure now established	Sarah Corcoran/Sue Ward	Mar-18	Quality and Safety Committee	Support available to patients and staff when needed	Sitle level meetings now in place for the larger sites Policies drafted and iun some cases approved

Principal Risk: If appropriate systems and processes are not in place to support End of Life Care this could result in poor experience for patients and their families approaching end of life and variation in service delivery (Risk 4548)			Enabling Strategy: Palliative and End of Life Strategy 2016-2018 Lead Director: Chief Nurse			Associated Committee: Adult Palliative and End of Life Group Operational Lead: Deputy Director of Nursing (Professional Practice)		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Variation in the levels of assurance which can evidence the delivery of End of Life Care across the different models across the Trust Risk of poor experience for patient's and their family approaching the end of life	1.Executive lead for End of Life care - Chief Nurse, who chairs Executive Oversight Task and Finish Group 2. Reporting and goverance structure implemented from December 2015 to drive improvements 3. Adult Palliative and End of Life Group and Babies, Children and Young People End of Life Group chaired by clinical leads 4. Palliative and End of Life care strategic plans and work programmes delivered through respective groups, overseen by Executive Oversight Group. 5. Implemented Adults Priorities of Care for the Dying Person care plan to support evidence based care delivery for patients and families 6.Trust audit of adult End of Life Care undertaken January-March 2015 and presented to Clinical Effectiveness Committee 7. National End of Life Care audit results 8. Revision and updating of number of policies and guidelines available through the Specialist Palliative Care website to support evidence based quality end of life care 9. Approval of business case for expanded palliative care services for adults and implementation of 7 day palliative care nursing service 10. Participating in the NHS England programme, Transforming EoLC in Acute Hospitals Programme 11. National Care of Dying Audit outcome for Trust demonstrate above average compliance with the 5 clinical quality indicators reviewed. Trust audits of EoLC documenation undertaken in Quarter	9 3x3	None	Variation in evidence to demonstrate that palliative and end of life care to patients and their families is evidence based and meets their individual needs across the different models within the Trust.	Palliative and End of Life Care Strategy including Children, ratified at Quality Committee March 2016 Reports to Quality Committee from Palliative and End of Life Work Groups delivering related work programmes Updates to Risk Managment Committee, with risk reduced in May 2016 to 3x3 = 9 End of Life Oversight Group Working Groups work programmes monitored through the End of Life Oversight Group to ensure delivery of actions National Care of the Dying Audit results 7 day per week palliative care nursing service implemented in January 2017. Recruitment process for the additional palliative care consultant Medical or Nursing or ANP resource planned to take place during quarter 1 & 2 of 2017/18 Pilot of 'Comfort' observations for patients recieving EoLC Participation in National Transformation programme ACP and Rapid Discharge, Participation National Dying Matters Week Feedback cards for patient relatives in draft, complaint review by EoLC Matron	Audits completed as follows: Care of Deceased Adult Care of Deceased Child/Young Person Audit of Adult priorities of care individualised care plan standards Audit of Child/Young Person invidualised care plan standards Results from National End of Life Care Audit in Adult patients demonstrates good compliance with standards. End of Life Care Dashboard (adults) Internal Review - postive results Completion of Adult Morturay corridor and 'offices' works Divisional work plans in progress to address variation in EoLC	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Implemenation of End of Life Strategy and work programmes Development of mechamisms to gain feedback from families in relation to end of life care	Dawn Pike Director of Nursing	On going Q2 2017	Quality Committee	Assurance that EOLC is consistently high quality and evidenced based across all care settings	Work programmes progressing in line with expected delivery dates. 2 Palliative Care Consultants appointed in line with CQC recommendations. positive MIAA audit report highlighting good practice. Work to develop patient experience feedback mechanisms progressing - patient stories collected and feedback cards introduced. Work planned to align EoL strategies across MFT.

Principal Risk: If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation			Enabling Strategy: Quality and Safety Strategy Lead Director: Chief Nurse				Associated Committee: Quality and Safety Committee Operational Lead: Group Deputy Chief Nurse		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Adverse patient experience Damage to the Trust reputation Failure to comply with regulatory standards	1. Corporate and hospital/divisional Quality governance and delivery structures 2. Environment of Care Group supported by relevant expert groups oversees delivery of work programme and monitors impact through patient feedback mechanisms. 3. Contract monitoring focused on patient experience outcomes. 4. Monitoring systems in place for complaints, concerns and compliments. 5. Revised Complaints Policy and processes in place with addendum pending development of an integrated policy for the new Trust. 6. Complaints management guidance provided to Divisions - January 2017 7. Complaints KPI meeting chaired by Chief Nurse - reduction in over 41 day complaints 8. Improving Quality Programme in place across the Trust 9. Patient Experience programme launched in November 2016.	**9** **3x3**	1. Data systems for collection and management of patient experience feedback require updating. 2. Patient experience framework - What Matters to Me - not yet fully embedded across the Trust	1. Score below average for pain management, cleanliness and food in national inpatient surveys.	1. Reports to Quality Committee/Qualitty and Safety Committee 2. Performance reporting to BoD. 3. Internal and external Patient survey results. 4. Quality Care Rounds and Patient Expereince Tracker data. 5. Joint audits of compliance with standards with Sodexo 6. Accreditation outcomes 7. Outcomes of the Quality Reviews reported to Board of Directors. 8. Harm free care data monitored and exceptions reported to Nursing and Midwifery Professional Forum 9.Reports to the Board of Directors and its sub-committees on progress and results of the Accreditation Programme 10. External reports such as CQC assessent 11. Friends and Family Test	1. Improvements in care evident from Quality Care Rounds and Patient Experience Tracker data. 2. Accreditation outcomes 3.Wythenshawe site audit data	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Embed Patient Experience Framework - WMTM across MFT Refresh Brilliant Basics and Keep Me Safe Programmes to align with patient experience programme Deliver Dining Action Plan Deliver Enviroment of Care Group work programme	Hospital Directors Deputy Chief Nurse and Assistant Chief Nurse (Quality, Professional Practice and Cancer)	Mar-18	Quality and Safety Committee	Improve areas of patient experience that consistently score below average in national patient surveys	Good engagement with, and spread ofWhat Matters to Me (WMTM) approach to patient experience - from staff and patients. Engagement work planned with Wythenshawe teams on 12th February 2018 to develop WMTM for MFT. Ongoing improvement plan for food and nutrition. Second FM Matron in post on central site and FM Matron in post on Wythenshawe site (FM Matron Team now totals 3wte) enabling dedicated leads for food/nutrition and environment. Overall Quality Scores exceed target of 85% with 95.7% for Quality of Care Round and 89.6% for Patient Exoerience Tracker (former CMFT data YTD 2017/18). 42 wards/clinical areas accredited as Gold or Diamond across all MFT sites year to date. Environment of Care work programme on track.

Principal Risk: If we do not have an embedded transformation programme we will not be able to improve the experience and services for patients at the scale and pace required			Enabling Strategy: Transformation strategy /Quality Strategy/OD&T Strategy Lead Director: Chief Operating Officer				Associated Committee: Transformation Operational Board Operational Lead: Group Chief Tranformation Officer & Deputy Group COO	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
6 **3x2**	We do not deliver improved quality, experience or the financial savings. We will not deliver sustainable change at the pace and scale required.	Transformation annual plan approved by BODs with quarterly progress report to TMB and BODs Monthly Divisional Reports Monthly Transformation Operational Board Updates to Quality Committee & Finance Scrutiny Committee Quality Gate Reviews PMO Governance Process PIDs with KPIs and measurements	**6** **3x2**	Lack of upto date benchmarking information to assess against peers and identify/assess areas for opportunities. Ability to routinely measure progress against SAFER, elective and outpatient standards as data is not automated.	Membership of Dr Foster tools reduced. Work ongoing with informatics to ensure meansurement.	Shelford Transformation Network used to benchmark specific measurements Contribute to NHS Benchmarking Projects Annual Trust Capacity Tool designed to benchmark through HES data Get It Right First Time programme	n/a	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Embed SAFER, elective and outpatient standards	Divisional Directors / Clinical Heads of Division. Transformation team and leads.	31/12/2018	Transformation Operational Board	Standards to become business as usual	Updates on progress presented to Quliaty Committee.

4	Strategic Aim: To achieve financial sustainability

Principal Risk: If the Trust fails to consolidate financial recovery achieved by CMFT/UHSM and /or to meet further annual efficiency challenges as these arrive then the Trust may not be financially sustainable.	Enabling Strategy: -	Associated Committee: Finance Scrutiny Committee & Risk Management Committee
	Lead Director: Chief Finance Officer	Operational Lead(s): Hospital Finance Directors

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 5x4	Breach of Control Total leading to loss of Sustainability Funding would significantly jeopardise the ability to invest in and sustain improvments for patients	1. Review meetings are arranged over late February and early March to understand in detail and assess the state of development into delivery, across Hospital & MCS delivery plans for 2018/19 2. A set of "Financial Special Measures" escalated controls over expenditure, has been implemented in the MRI through January. An intense process of total budget re-building is continuing in MRI alongside the operation of these controls 3. Progress with 2018/19 delivery plans will be reviewed in detail at the Finance Scrutiny Committee on March 14th. 4. All delivery plans will continue to benefit from structured Quality Impact Assessments at Hospital/MCS and where appropriate, also at Group level.	20 5x4	None	None	Each month the Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, this is then aggregated into an overall Hospital/MCS rating across all the domains which determines the level of recognition, intervention and support required which is signed of by the Chief Operating Officer and the Chief Finance Officer.	An extensive framework of review, challenge and escalation is fully embedded within the organisation The current trading positions of the Trust continues to demonstrate delivery of established trajectories in line with Operational Plans	**12** **3x4**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring	Planned Outcome	Progress Evaluation
Sustained delivery against forecast trajectories remains critical to risk reduction. Progress against delivery will be examined at Finance Scrutiny Committee.	Hospital Leadership Teams	Monthly	Finance Scrutiny Committee	-	-

Principal Risk: Delay in implementation of Informatics Strategy due to cultural, behavioural and changing landscape.	Enabling Strategy: New Strategy to be confirmed.	Associated Committee: Group Informatics Strategy Board
	Lead Director: Alison Dailly	Operational Lead: Group Chief Informatics Officer , Corporate Directors and Hospital CEO's

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 **4x3**	Trust remains at a low level of digital maturity, impacting on delivery of benefits, patient care and reputation	Monitoring of * Delivery of Informatics Plan. * Benefits Realisation - Qualitative and Quantitative. * Digital Maturity index for Trust. * Corporate Steering Group monitoring of Informatics PTIP Plan.	6 3x2	Change in external landscape	The significant workload to understand the landscape of the 2 organisations and the planned programmes of work.	Introduction of SHS Informatics Governance in 2018/19 Group Management Board approval made in January 2018 to go to Open Procurement for an EPR. Strategy work commissioned for expected completion by end of March 2018.	Monitoring against HIMSS digital maturity Index. Regular updates to Hospitals and Corporate. Informatics Membership on Boards. Informatics PTIP Reporting	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Robust Monthly Monitoring against plans	Alison Dailly	Monthly	Group Informatics Strategy Board	Achieving priority	as per controls

5	Strategic Aim: To develop single services that build on the best from across all our hospitals

Principal Risk: There is a risk that commissioners will further consolidate specialised services at a regional or national level (e.g. ACHD), where MFT is not made the designated provider.	Enabling Strategy: TBC	Associated Committee: Board of Directors
	Lead Director: Executive Director of Strategy	Operational Lead: Informatics , Corporate and Hospital CEO's

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
9 3 x 3	Loss of service leading to reduction in range of services offered within GM and, as an impact, loss of income, damage to reputation, loss of staff and reduction in research opportunities.	Involvement in the GM Partnership forums to provide a united voice on maintaining GM-based services. Involvement in strategic clinical networks Regular discussions with NHS England Medical Director Representation through the Shelford group Active involvement in Operational Delivery Networks	6 3 x 2	Management capacity to action the risks and issues identified in the Quality surveillance reviews	Links with MFT clinicians with local, regional or national clinical leadership roles.	Outcome of quality surveillance reviews Designation as lead provider	Status as largest provider Trust and with highest proportion of specialised services nationally Ability to offer co-located services Track record of being made lead transformation provider for paeds, breast surgery, vascular services, urology cancer surgery and breast services.	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Developing a process to better manage the annual survellience reviews across central and Wythenshawe sites with oversight and governance arrangements	John Wareing	Apr-18	Group Management Board	Have a trust wide process for the annual reviews	In progress

Principal Risk: The governance arrangements for health and social care in Greater Manchester increase the emphasis on delivering benefits for the whole of GM, rather than in the interest of individual organisations.	Enabling Strategy: Taking Charge - Manchester Stategic plan	Associated Committee: TBC
	Lead Director: Executive Director of Strategy	Operational Lead: TBC

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
8 4x2	Decisions taken through the governance structure (through Strategic Partnership Board and Provider Federation Board) may not reflect MFT plans for the development of our services.	MFT representatives on SPB, PFB, Chairs' group, HR, DoFs, Director's of Strategy, Directors of Ops, JCB Executive Group etc. MFT representatives on Theme 3 Board and Theme 3 Executive PFB enables providers to engage as a group with GM Devolution Process in place for GM decision making which involves and recognises the Trust's decision making requirements Development of MFT clinical service strategy, taking GM decisions into account and forming coherent strategies for the Trust.	6 3x2	Voting structures are based on majority voting (75% majority) with a single vote for each stakeholder group (NHS England, local authorities, CCGs, providers).		MFT designated lead provider in other key specialties GM model for benign urology aligns with MFT model	MFT already made lead transformation provider for Healthier Together, paeds, gynae cancer, breast surgery, vascular services and respiratory and the joint transformation lead (with Bolton) for cardiac. MFT (Wythenshawe) designated lead provider for urology cancer surgery Increased size of Trust following merger, and influence that follows that	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continual attendance by Chair, Chief Exec, Director of Stategy at GM meetings, fully briefed by strategy team	Strategy team	Ongoing	Board of Directors	Ongoing ability to influence GM decisions that impact on MFT	Ongoing
Develop the MFT clinical service strategy and underpinning service level strategies.	Strategy team	Dec-18	Group Management Board	A MFT clinical strategy that reflects GM decisions and develops an appropriate strategic vision and plans for the Trust, underpinned by detailed strategies for groups of services.	In progress

Principal Risk to Key Priority: If there is a lack of clinical buy-in this could impact negatively on the achievement of single services			Enabling Strategy			Associated Committee	
			Transformation Strategy and Leadership and Culture strategy			SHS Programme Board	
			Lead Director			Operational Lead	
			Joint-Medical Director			Group Deputy Director of Workforce & OD	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
6 3X2	Failure to achieve clinical buy-in could mean that although the Trusts technically become a single organisation, the clinical staff do not work together and become single teams functioning as single services.	Clinical engagement sessions held in early phases of review that led to the recommendation of SHS in order to increase collaboration across Trusts Appointment of clinical leads in SHS team Clinical engagement in development of clinical services framework Clinical engagement in development of single service models for individual specialties Creation of clinical structure for SHS that facilitates collaboration across sites and agreement on single service models Clinical Advisory Group established. OD programme in place Operations and transformation working group established that incorporates OD elements Appointment of Joint Medical Directors to Interim Board Clinical representation on the Values and behaviours steering group	3 3x1	Feedback that key information and messages relating to the new organisation are not being cascaded fully to clinical teams	History of failed attempts at collaboration. No routine mechanism to assess attitude to merger	Lessons learned from previous service mergers Results of next quarterly staff online pulse check survey (Q4) about Single Hospital Service (Q3 is national staff survey so won't be asking at this point).	Positive feedback on values and behaviours work through ACE day cascade. Feedback from engagement events (SHS updates to BoD) Level of clinical involvement in SHS events (SHS updates to BoD) Areas where clinicians are already working together - cardio-respiratory, urology (theme 3), vascular (theme 3), Progress with Healthier Together (SD update to BoD) Results of quarterly staff online pulse check surveys two questions about Single Hospital Service from Q1 and Q2 (medical and dental staff specifically): • 75% of 176 respondents agree or strongly agree that they are regularly informed of progress in developing the Single Hospital Service • 56% of 175 respondents agree or strongly agree that they understand the benefits to patients of Single Hospital Service	3 3x1

Clinical engagement in design of new organisational arrangements

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Values and behaviours work shared and discussed via quarterly ACE days and poll	OD team and divisional management teams	End Sept - start nov	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Information and messages relating to the merger shared with newly qualified consultants as part of the NACs programme.	OD team and Medical Directors	12th October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement events with briefings from the Chief Executive	Communication team	September to October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement sesssions led by Executive Directors	OD team	Tranche 1: August - September Tranche 2: October - November	SHS Programme Board	Continued staff awareness of and engagement in activites relating to delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Delivering tailored support to 27 teams that make up the 'Operational and Transformation project list'	OD, transformation and SHS teams	Ongoing	Transformation & Operations Oversight Committee	Rapid delivery of benefits relating to the merger.	Ongoing
Opportunity provided to share and discuss values and behaviours work with all staff during NHS Change week	OD team	Week commencing 13 November	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Circulate enabling strategies (Transformation and Leadership and Culture) during NHS Change week	OD and transformation teams	Week commencing 13 November	SHS Programme Board	Awareness of and engagement in implementing strategies for delivering benefits of the merger.	Completed
Values and behaviours framework developed by hospital leadership teams to be approved at GMB (May 2018)	OD team	21st May 2018	Workforce & Education Committee	MFT values & behaviors framework to support the development of the organisation's culture	Ongoing
New timetable of CEO Staff Engagement Events	Communication team	6 Monthly	Workforce & Education Committee	Supporting staff - listening and continuing engagement, encouraging creativity	Ongoing

6	Strategic Aim: To develop our research portfolio and deliver cutting edge care to patients

Principal Risk: If there is a failure to secure Genomic clinical laboratory redesignation then there could be loss of staff, reduced income and an negative impact on reputation	Enabling Strategy	Associated Committee:
	-	Group Service Strategy Committee & Research Effectiveness Committee
	Lead Director:	Operational Lead:
	Joint Medical Director	CEO - Saint Mary's Hospital

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
6 3x2	Risk to clinical incomes. Loss of key clinical academic staff. Impact on research standing. Weakens Precision Medicine proposition	CHD Structure. Engagement with external partners	12 4x3	This is partly reliant on external organisations	(redacted commercially sensitive) (redacted commercially sensitive)	(redacted commercially sensitive) (redacted commercially sensitive)	Documented relationships with external partners; engagement with UoM and GM H&SC Partnership	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1. Strengthen genomic medicine centre capability and research quality 2. Develop informatics strategy 3. Regional stakeholder engagement sessions	1. Graeme Black 2. Graeme Black 3. Lorraine Gaunt	1. 2017 Q1 - Q3 2. 2017 Q2 - Q4 3. 2017 Q3. COMPLETED.	1. Divisional Management Board - SMH and R&I 2. Genomic Med Operational Development Group 3. Genomic Med Strategy Board	1. Secure designation as one of 8 national clinical genomics hub centre with NHS/Genetics England. 2. Documented informatics strategy to meet need of specification requirements, risks documented, business case developed 3. Increased stakeholder engagement. Stakeholder related risks identifed and mitigation plans in place	1-4. Monthly reporting from Trust Management Board. Draft Service specification issued by NHSE. Attendance all all provider days in place. Genomic Med Operational Development Group now established

7	Strategic Aim: To develop our workforce enabling each member of staff to reach their full potential.

Principal Risk: If the OD Strategy and therefore a high performing, inclusive and values based culture that increases organisational resilience and agility and City of Manchester system leadership and integration (LCO) is not implemented then quality, safety and patient experience may be compromised.			Enabling Strategy OD Strategy Lead Director Executive Director of Workforce & OD			Associated Committee HR Scrutiny Committee Operational Lead Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 3x4	1. Insuffient number of high calibre leaders for business critical roles 2. Poor culture (including leadership) undermines Trust performance 3. Unable to maximise the organisational opportunities offered by the Manchester Transformation agenda 4. Low functioning teams impacting on the quality of care 5 Poor staff engagment and therefore low advocacy and impact on patient care	Deputy Group Director of Workforce and OD lead and set clear objectives for OD&T team Hospital HRD s in place Leadership and Culture Strategy and implementation plan approved Appraisal policy in place and quality standards monitored Service level Workforce Plans in place Accountability Oversight Frameowrk with KPIs to measure performance HRBP Model in place to support local Managers and Leaders. People Management Skills programme in place Revised ED&I strategy developed and approved	**9 3x3**	1. No Systematic Values Based Recruitment process 2. No Talent Management and succession plans	1. No Systematic application and monitoring of a talent management process. 2. Not testing values at recruitment 3. Poor HR I.T. systems to support monitoring and lack of informatics expertise.	1. Accountability oversight framework 2. Staff engagement in hospital/turnaround and transformation programmes reported to HR Scrutiny Committee and Transformation and Operations Oversight Committee 3. Leadership development outputs reported to HR Scrutiny Committee and Transformation and Operations Oversight Committee 4. Speak Out campaign reported to Clinical Effectiveness Committee 5. Appraisal training - HR Scrutiny Committee 6. Pulse Checks results reported into HR Scrutiny Committee	1. Top 20% of Trusts for Staff Engagement 2. Top 20% of Trusts for staff advocacy rates 3. Staff attendance on leadership and management programmes 4. 90 % compliance with appraisals 5. Transformation Case studies and assurance reported to the Transformational and Operations Committee 6. 90% compliance with Clinical Mandatory training 7. 90% compliance with Corporate Mandatory training 8. Assurances for all of the above are reported to HR Scrutiny Committee and Trust Risk Committee	**6 2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1 Complete Phase 3 of NHS Improvement Culture Programme to develop Leadership and Culture Strategy 2. Secure investment from Transformation fund for implementation of intergration OD plans 3. Implement actions arising from 2017 staff survey 4. Finalise development and embedding of values and behaviours in line with integration plans and leadership and culture strategy 5. Continue quarterly pulse checks to monitor staff experience 6. Expand delivery of VBR incrementally within current capacity and capability 7. Support Hospitals with the implementation of staff engagement and medical engagement programmes 8. OD& T Business Plan 2018-19 9.. Implement Leadership & Culture Strategy	HR/OD&T	Mar-18	HR Scrutiny Committee	Maintain the 2017 response rate to Staff Survey Improve Staff engagement score to within top 20% Number of key findings in the staff satisfaction survey scoring in the top 20% increased	1. Insuffient number of high calibre leaders for business critical roles 2. Poor culture (including leadership) undermines Trust performance 3. Unable to maximise the organisational opportunities offered by the Manchester Transformation agenda 4. Low functioning teams impacting on the quality of care 5 Poor staff engagment and therefore low advocacy and impact on patient care

Principal Risk: If the organisation is unable to deliver the best quality assured education and training then workforce capability and capacity, quality, safety and patient experience may be compromised.			Enabling Strategy			Associated Committee		
						Strategic Education and Workforce Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	1. capability and capacity compromised- leading to poor performance and poor quality of care 2. Lack of flexibility to change and implement quality improvements 3. staff vacancies and diffuclt to fill critical posts 4. high turnover 5. lack of innovation 6. Limited succession planning 7. Negative impact on Trust reputation	1. Learning and Education Policy 2.Induction and Mandatory Training Policy 3. Learning and Development Agreement 4. Education Quality Review process (Medical) 5. University, Deanery and GMC surveys 6. Leadership and Mangement Development Programmes 7. Apprenticeship Strategy in place	**12** **4x3**	1. Consistent and collective education and training evaluation process 2. Integrated Learning and Education Strategy 3. Lack of consistent and collective training needs analysis process 4. Workforce planning process not fully embedded 5. Unclear of impact of post bursery and education funding gaps	1. Assessment of quality of education and training provided by OD&T 2. Organisational Training needs analysis beyond mandatory training. 3. Development of national standards for Apprenticeships and impact levy spend	1. Cross professional learning and education monitored and reported to HR Scrutiny Committee via the Workforce and Education Committee 2. Apprenticeship programme monitoterd and reported to the Apprenticeship Steering Group and into the Workforce and Education Committee and HR Scrutiny Committee 3. Medical Education Board 4. GM Nurse Associate Partnership and PMO 5. individual professional risk registers 6. Healthcare Science Workforce Group	1. Meeting our staff retention targets 2. Top 20% of Trusts for staff engagement and learning development as part of staff survey results 3. 90% compliance with Mandatory training 4. Meeting our apprentice starter target 5. Student/trainee feedback 6. GMC Surveys and benchmarks 7. Accreditation and accredited services	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
• Deliver an active and engaging Widening Participation Programme • Expand and develop apprentice programme in line with national targets and MFT strategy • Deliver actions set out in the Talent for Care strategy • Develop an MFT integrated Learning and Education Strategy • Coordinate learning and education evaluation • Ensure that the positive aspects of and improvements made to the service are communicated to staff across the Group • The GM PMO programme of work around Nurse Associate and Graduate Nurses • Deliver the N & M Workforce Group programme of work	HR, AHP and Scientists, Nursing and Midwifery and Medical education	Mar-18	Newly establsihed Workforce and Education Committee	• Mandatory Training compliance at 90% • Achieve national target for new apprenticeship targets • To be above average (as compared to benchmark group) for all indicators relating to pledge 2 of the staff survey 'to provide staff with personal development, access to appropriate training and education to do their jobs and line management support to enable them to fulfil their potential • To be in the top 20% of Trusts for staff enagement • Improvements in the Junior Doctors experience where this has been identified as a requirement by the GMC/Deanery survey	• Continued to deliver supported internships and pre-employment opportunities through active involvement with schools. - Nurse Associate apprenticeship programme due to start in April • Apprenticeship programme now expanded to include A&C Apprenticeships and 25 staff have successfully secured places on the new Chartered Management Degree Apprenticeship • All potential apprentiship opportunities being scoped out via the Apprenticeship Steering Group • Talent for Care strategy actions implemented including improving learner facilities • Integtrated Workforce and Education Committee establsihed and being developed to lead learning and education strategy for MFT • Integrated Mandatory training programme and policy under development in line with PTIP

Principal Risk: If there is a loss of funding for teaching for Undergraduate Education,(SIFT - Service Increment For Teaching) and/or changes made to the training programme by the University this could result in a reduced ability to fund the infrastructure required to deliver high quality education.			Enabling Strategy			Associated Committee		
			-			-		
			Lead Director			Operational Lead		
			Joint Medical Directors			Associate Director (Operational) Medical Education		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 4x3	Impacts on the ability to fund the infrastructure required to deliver high quality medical education.	1. Close monitoring of income/spend 2. Reduced the overall cost of the service. 3. Prevent loss of further income	12 4x3	Inability to influence the decisions made by the University re student placements	None	Monthly review of budgets with Divisional Accountant which forms the basis of a Divisional report shared with Senior finance officers . Comparison of reference cost, the results of which are signed off by the Director of Finance before being circulated	Feedback from yearly Student survey undertaken by the University, the results of which are sent to the Medical Director. Success rates for Medical exams - (97.35% in 16/17)	8 4x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Explore further options to reduce the cost of the service	G Terriere	Jun-17	Turnaround	Deliver 17/18 Trading gap	Achieved 01/04/17
Explore possibilities of increasing income	G Terriere	Jul-17	Turnaround	Possibility of Financial model to be introduced in 17/18	Initial discussion with Head of Medical school re amended funding model which would potentially increase the income to MFT. This has not yet been agreed by Health Education England. And therefore unlikely to have an impact om 17/18.
Explore possibility of increasing the number of students who undertake their projects at MFT	G Terriere	Jun-17	Turnaround	Increased student weeks and income	Increase in student numbers achieved which should be reflected in income for 18/19

Principal Risk: If the Trust fails to meet statutory Equality and Diversity obligations then the perceived reputation of the Trust as an employer of choice may be negatively impcted upon. Trust risk numbers - 2503C/5378U			Enabling Strategy			Associated Committee		
			ED&I Strategy			HR Scruntiny Committee/Quality Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Associate Director of ED&I and Commuinities		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Negative financial impact and negative impact on CMFT's Brand. Impacts ability to recruit the best staff	1. Governance reviewed to ensure clear accountability for ED&I 2. Strategy signed off by CMFT Board in Nov 2015 & first year of the action plan completed. 3. KPI tracked at the board level on the retention of BME staff 4. Systems in place e.g. WRES, EDS 2 and Equality Impact Assessments	**12** **3x4**	1.Budget constraints mean that not all work is funded 2. Widening Participation/Community Engagement Strategy not yet set	1. Staff behaviour, whilst supported by clear HR policies and the Values programme will continue to be a risk for any employer aspiring to be a leader in the ED&I field. 2. Resource pressures on the Trust to deliver new mandated programmes by NHS England and HT/GM 3. Not all the ED&I data is robust with gaps in monitoring and quality for specfic protected characteristics 4. We are seeing a rise in patients being abusive to our staff with a focus on racist abuse	1. New strategy and action plan set in Nov 15 - monitored by the HR Scrutiny Committee & the Governor Performance Group 2. Action plan in place for WRES - monitored by the HR Scrutiny Committee. 3. Issues regarding accessibility are reported and monitoed as the Trust Accessibility Board 4. The cultural diagnostics developed with NHSi provide additional indepth analysis of culture in CMFT's hospitals.	1. No further high profile Employment Tribunals have taken place - monitored by the HR teams 2. The Trust has started to win awards as a Inclusive Organisation 3. CQC report outlined progress in ED&I 4. Removed off the EHRC watch list 5. BME staff retention meeting standard retention rate	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1. Deliver the actions as outlined in the ED&I Strategy Action Plan. 2. Improve patient data through the Patient Profiling Working Group with Divisional Leads. 3. Improve workforce profile data through a campaign with colleagues. 4. Embed Equality Impact Assessments into all aspects of decision making. 5. Enhance the mechanism for staff to report incidents relating to ED&I through the Trusts systems, monitor and develop programmes to address key areas of concern. 6. Implement new KPI to monitor recruitment/promotion of BME staff	Associate Dir ED&I	Apr-19	HR Scruntiny Committee	Reduction in patient complaints & Improvement is staff survey results	key metrics on staff and patient engagement New KPI built into Intelligent Board report Pilot of trained BME managers on panel interviews for posts baded 8a and above ED&I team redesigned to support delivery of group priorities

Principal Risk: If there is inadequate focus on: workforce information and policies, workforce design and succession planning, attraction and resourcing; staff engagement; talent and performance management this may result in a negative working environment, loss of discretionay effort, productivity and high staff turnover / vacancies			Enabling Strategy: People Strategy Lead Director: Executive Director of HR and OD			Associated Committee: HR Scrutiny Committee Operational Lead: Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **3x4**	Inability to attract, source and recruit the right numbers of skilled people aligned to our workforce plans and culture. High Temporary Staffing costs. Potential negative effect on staff morale, engagement and wellbeing. Inability to support the implementation of new service delivery models and maximise opportunities presented by the Manchester Transformation agenda. Increased potential for employee litigation as a consequence of TUPE/service change.	• Trust wide People Strategy against 5 deliverables delivered through detailed HR work plan for 2017/18 that is reviewed on a quarterly basis. Underpinned by KPI's that are reported monthly to GMB and BoD • Comprehensive Divisional workforce plans aligned to Business plans and the People Strategy. • Executive scrutiny of vacancy levels, Hospital vacancy control panel, agency and bank expenditure financial anlaysis and reporting and compliance with NHSI agency reporting requirements. Consistency panels for consultant recruitment. • Trust wide attraction strategy for all roles. International and domestic (Proud to Care) recruitment campaigns for nursing and other hard to fill roles. Consultant recruitment campaigns for hard to fill posts and joint attraction strateg for single hospital service including North Manchester General. • HR service delivered through HRBP delivery model with realigned resource to meet demand and aligned to each Division. Comprehenisve HR policy framework in operation with regular review. • Medical Workforce Project Group to drive and support maximising medical workforce contribution and devolved to Hospital teams for delivery. • Working in partnership with staff side to ensure positive employment relations culture. • Electronic job planning model introduced for medical staff with comprehensive training to support implementation and identified approach to team job planning. • Introduction of new Health & Wellbeing serivce model with development of Health and Wellbeing Strategy. • Development of Electronic Workforce Intelligence Portal (EWIP) reporting model and HR portal supporting performance data analysis. • Support to Apprenticeship Strategy supporting the delivery of new roles and career pathways, talent management and local community attraction across the whole workforce.	**9** **3x3**	Commitment to values based recruitment practice to strengthen selection processes across all staff groups. Capacity with both HR and line managers to deliver buisness as usual and transformational change. Impact of external market forces on hard to fill posts and agency supply and cost. Low control over actions of others within wider GM. Ongoing development and refinement of HR IT systems to support monitoring & people management	Fully embedding lessons learnt in future ER practice underpinned by inadequate case management reporting system. Maintaining attendance at 96.4% -	**Reported to Operational Workforce Committee** Implementation and outcomes of change programmes. Outcomes of batch recruitment campaigns for hard to fill areas. Employee Relations activity and outcomes. HR Governance and Performance Committee assurance. **Reported to HR Scrutiny Committee** Reduction in bank and agency. spend to cover sickness absence. Reduction in sickness absence rates. Staff Survey & Pulse Checks. Delivery of People Strategy deliverables. **Trust wide** Hospital reviews against Accountability Oversight Framework. Quality Reviews Speak Out campaign People and Development Performance Dashboard with Workforce KPIs NHSI Agency Caps reported on a weekly basis and data monitored for compliance **Reported to Strategic Workforce and Education Committee** Workforce plans	Key metrics delivered as reported in the new People & Development Performance Dashboard and Accountability Oversight Framework. Vacancies reduced to 5% (all staff groups) by March 2018. Time taken to fill vacancies achieved revised target of 55 days in Janaury 2018. Retention of staff with over 12 months service at more than 80%. Revised target set to 89% Maintaining attendance at 96.4%.	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comparative assessment of HR IT solutions and systems between CMFT & UHSM for HR areas of practice and development of visiosn for HR systems for the single hospital service. Continue to develop managers' competence and capability on people management issues. Further development of the HRBP model to support managers through the provision of advice, guidance and information. Ongoing development of workforce planning and data collection and analysis via ESR, including automation of operational processes to improve efficiency of service delivery. Further development of e-Wip and ESR to support the production of meaningful workforce intelligence including the launch of the HR Console for key performance metrics. Develop resources to equip the Trust to plan and implement organisational and system wide change, including development of a suite of HR tools to support collaborative management arrangements and integration. Delivery of Proud to Care nurse recruitment campaigns using social media and engaging candidates strongly in the organisation at an early stage. Evaluation of new HR model for delivery with resource, capacity and capability to deliver the People strategy. Support to targeted work programmes for maintaining attendance with identified staff groups. Delivery of competence and values based selection processes on an incremental scale within current capacity and capability. Introduce modern approaches to attraction and selection that will enhance our position as an employer of choice in the market, both local, national and international. Review of consultant recruitment processes to enhance the candidate experience, revisit the investment proposal for nehanced consutlant recruitment processes and, if investment secured, consider the application of values based recruitment. Develop and implement the new employee health and wellbeing delivery model and strategy. Develop framework to integrate learning from employee relations cases.	HR/OD&T	Planned phased delivery throughout 2017/18	HR Scrutiny Committee. Operational Workforce Committee. Strategic Workforce and Education Committee HR Performance & Governance Group Governor Staff Experience Group	Compliance to Divisional and Trust sickness absence trajectories/targets Maintain the staff response rate (Staff Survey) to ensure it is either equal to or above the national average. To be above average (as compared to benchmark group) for all indicators relating to pledge 3 of the staff survey 'To provide support and opportunities for staff to maintain their health, wellbeing and safety'. Ongoing delivery of efficient and effective NHS compliant recruitment practice. Vacancy rates reduced to 5% through planned and coordinated recruitment campaigns and processes and the delivery of strong retention interventions. Agreed approach to managing workforce issues across integrated services supported by HR protocols and operational guidance. Clear understanding of health and social care workforce resource and development requirements. To achieve improvements in performance against key metrics as defined in the People Strategy. Positive employment relations culture.	People Strategy HR Work Plan 17/18 KPI's Development of KPI's for department performance