MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Report of:	Deputy Chief Executive – Silas Nicholls
Paper prepared by:	Executive Director Leads (MFT) Alwyn Hughes (Interim Trust Board Secretary - MFT)
Date of paper:	October 2017
Subject:	**Manchester University NHS Foundations Trust's Board Assurance Framework (BAF) – October 2017**
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 new organisation's combined Board Assurance Framework (BAF) – October 2017
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MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE FRAMEWORK
(October 2017)

1. Purpose

This paper asks the Board of Directors to receive the latest iteration of the combined Board Assurance Framework (BAF) for the new 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 BAF for the new FT. It is accepted that the BAF for the new FT will go through a number of iterations; both in the run up to the implementation of the merger and in the early months of the operation of the new FT as the Group Board of Directors and officers gain greater familiarity with the organisation's risk environment and as assurance processes are developed and matured.

3. Progress

The BAFs of the two previous organisations have been reviewed in detail, and the Interim Board of Directors received papers in August & September 2017 detailing an exercise, with support from the SHS legal advisors, to combine the contents of the former CMFT and UHSM Board Assurance Frameworks (informed by the two organisations risk registers) and creating a bespoke BAF for the new organisation.

The version of the BAF received by the Interim Board of Directors in early September 2017 has now been further refined and updated following feedback from lead Group Executive Directors who were invited to validate the risks on the combined BAF. In instances where the two organisations had very similar risks, Group Executive Directors were asked to agree wording of a new strategic risk appropriate to MFT with confirmation of the risk assessment and proposed action.

The combined BAF is now a 'live' document and ongoing review will take place with further iterations presented to the Board of Directors on a regular basis. The BAF will also be transferred onto the new organisation's integrated governance management system (Safeguard).

4. Recommendation

The Board of Directors is asked to receive the most up-to-date combined BAF (October 2017) for the Manchester University NHS Foundation Trust (MFT).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK (2017/18)

***** 2nd October 2017 *****

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 deliver the merger of the two organisations with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner

Principal Risk: If staff leave or are distracted during the merger process there is a risk to quality of service delivery pre and post merger .	Enabling Strategy	Associated Committee
	Single Hospital Service	Board of Directors
	Lead Director	Operational Lead
	Medical Director / Chief Nurse	Programme Director SHS

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	Quality of services could be negatively impacted during the transition phase.	Additional resource in place to support the operation of a SHS transition team SHS Team working closely with exisiting management teams	9 3x3	Management team capacity limited	Cannot fully assess the combined risk unitl after merger approval	Further clincial due diligence processes	Clinical due diligence processes NHSI Gap analysis Both organisaitonal CQC reports and associated improvement plans	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Work with all sites and the SHS Team on the clincal due diligence process Maintain internal quality assurance processes throughout	Director Clinical Governance	Sep-17	Quality Committee	Safe and effective service delivery during the merger proces	Good progress

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 and 5346U/ 4855U)			Enabling Strategy					Associated Committee
			Transformation Programme					Transformation Programme Board
			Lead Director					Operational Lead
			Chief Operating Officer					Director of Corporate Resilience
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	20 4x5	Resilient workforce and skill set 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 committee. Board of Directors	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Development and implementation of Trust Winter Plans Secured winter resilience funding and implementation of schemes 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.	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. Central/TGH have continuously delivered the GM DToC standard of 3.3%. However, performance at Wythenshawe site has been more challenged at circa 8%.

Principal Risk: If the processes for the communication of diagnostic and screening test results are not strengthened then patient harm will continue as a result of failure to communicate, interpret or act on those results (3305)	Enabling Strategy	Associated Committee
	-	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
20 4x5	Ineffective processes for sign off Results being sent to wrong location Delays in referral processes Delays in reporting processes Failure to act on results received	- Service processes / risk assessments for identifying managing their highest risk test pathways - Communication of test results policy - ICE electronic order commes and results reporting system - Chameleon View - Informatics Strategy Board - Wrong Blood in Tube Working Group - Critical test reporting systems - Digital Enablement Programme	16 4x4	Inconsistent processes and lack of standardisation - including dual electronic and paper systems for reporting Full roll out of Communicator (Radiology Reporting System) not yet complete Inadequate systems for monitoring performance outside of critical incident reporting	Lack of comprehensive performance monitoring	Clinical Audit of service processes A reduction in reported patient harm events and near misses	None as yet	4 2x8

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Dental Radiology Screens - Process underway but dependent on LIMS completion. Extension agreed.	TBC	29/09/2017			
Divisional risk assessment for paperless pathology reporting		20/09/2017		Effective, consistent undertaking of tests and communication of the results.	
Genetics requesting screens		31/07/2017			The impact of this risk continues without a significant reduction in harm and the work is continuing to address this.
Ensure safe transition and merge of systems following organisational change.		01/01/2019	Informatics Strategy Board	Effective assurance and monitoring processes in place and evidence of a reduction in harm.	This risk continues at a score of 16 with consideration being given to an increase in score if the harm level does not decrease in response to local action by October 2017.
All Divisional Clinical Effectiveness leads undertaking a review of local processes and pathways utilising incident data to identify high risk areas. This work is a review of a previous local review to support the corporate work programme.		01/01/2017			
Improve ICE archiving functionality 02/01/2017 29/06/2018		29/06/2018			

Principal Risk: If effective measures are not in place the Trust may fail to achieve Infection Control standards/targets and management of Carbapenemase-Producing Enterobacteriaceae (CPE) resulting in patient harm, extended length of stay and poor patient experience. (Risk 1970)			Enabling Strategy			Associated Committee		
			Trust Infection Prevention and Control Strategy and Annual Plan			Infection Control Committee		
			Lead Director			Operational Lead		
			Chief Nurse / Director of Infection Prevention			Infection Control Doctor and Infection Prevention Nurse Consultant		
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	Patients being cared for within our services acquire a hospital acquired CPE infection, which may impact on their clinical outcomes, extend length of stay and result in a poor experience.	Director of Infection Prevention identified as Chief Nurse Trust Infection Control Committee in place. Regular performance meetings Divisional Clinical Lead for Infection Prevention and Control Divisional Infection Control Committees report to Trust Infection Control Committee Antibiotic Prescribing Audits Regular Hand Hygiene audits with improvements to address any areas for improvement Evidence based policies, procedures and integrated care plans, in place to support evidence based care delivery Infection Control training part of corporate, clinical and divisional induction processes and on-going mandatory training. Proactive screening of all patients where new cases arise. Admission screening extended to include national guidance of all high risk patients Weekly screening of wards (on a rotational and risk assessment basis). doing circa 72,000 screens per year Policy for control and management of CPE in place. includes advice on appropriate personal protective equipment (PPE). Triggers and escalation processes in place for when threshold for isolation capacity breaches. Undertaking admission screening of known CPE KPC patients to establish if CPE still detected. Following a 'non detected' result each patient is risk assessed and followed up for the duration of their inpatient stay. Working in partnership with Public Health England on level 3 incident management of CPE. Isolation ward capacity within MRI and monitoring process through infection control team to manage 'CPE non detected' patients. Implementation of managed contract for the provision or Deprox decontamination technology.	16 4x4	None	None	Divisional Infection Control Committee report to Trust Infection Control Committee Infection Control and Prevention Annual Report Improvements in alert data, Dashboard data, HSMR/SHMI Training records within OLM Acquisition rates within the Trust	From April 2016 a new Trust screening process for patients who had been previously positive was implemented. All previously CPE positive adult patients have been re-screened on readmission. Of the 843 admissions, (April 2016 -March 2017) 519 (61.5%) were 'CPE not detected' on admission, which has meant these patients could be admitted to a standard ward environment with enhanced screening during their admission. Of these non detected patients 55 (10%) were identified as CPE positive during their admission and appropriate transfer to isolation facilities was arranged. The Trust is working with Public Health England to evaluation and understand the possible reasons/triggers for the patients changed in CPE status during their admission. As a result of this new screening policy between March 2016 and August 2016 the Trust was able to reduce the isolation/cohort bed numbers from four wards (85 beds) to one ward (27 beds) based on a sustained reduction in the number of in-patients with CPE. There was a significant decrease in the number of new cases of CPE from April 2016 – March 2017 compared to the previous year (from 512 cases to 378). The fieldwork for the TRACE research project finished week-ending 15th January 2017. The data is currently being analysed and a report will be available later this year. The IPC audit programme included a trust-wide audit of hand hygiene compliance.	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continue partnership work with PHE and TRACE project to inform evidence base	Andy Dogson	Sep-17	Infection Control Committee	Increased evidence base	Programme of research on plan

Principal Risk: If the clinical record is not managed or completed to a sufficient standard then clinical quality, safety and financial sustainability will be compromised. Risks 5045C/5048C/5300U	Enabling Strategy	Associated Committee
	Lead Director	Operational Lead
	Medical Director / Chief Nurse and 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
16 4x4	Patients may come to harm The Trust may fail to meet statutory requirements The Trust may not receive the correct income for care delivered The Trust may not be able to generate correct and consistent patient care data/information	Risks associated with management of the record, content of the record and information governance are all detailed on the Risk Register with associated action plans Clinical audit programme Internal audit programme IM&T Strategy Medical Records Improvement Project	16 4x4	Inconsistent compliance with record keeping policies Dual paper and electronic record Multiple electronic systems in place - including two different PAS systems	Trust wide audit programme not in place	Trust wide audit programme		8 4x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Risks associated with management of the record, content of the record and information governance are all detailed on the Risk Register with associated action plans					

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 Director	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	CHD structure CD structure CD Programme and leadership development Standards of clinical care Pathways in place NICE/NCEPOD monitoring High Level Investigation thematic reviews Mortality Review Group in place Coding validation results Revalidation and appraisal process Patient safety projects Clinical audit processes	16 4x4	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 Quality Review Process Central Portal GMC survey data Monthly CQC feedback Full evaluation of Leadership schemes	Aqua Regional Report on Mortality	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Development of a joint work programme by the Clinical Effectiveness 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.	Sarah Corcoran Alison Daily	2018	CEC	SHMI <100 HSMR <100	SHMI >100 HSMR>100 The Combined SHMI fro MFT is 103, down from CMFT but an increase for UHSM 96

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 Corporate Resilience		
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 Weekly meetings in place with the COO for high risk tests. Recovery trajectories in place Monthly forecasting in place for all sites	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 in place with underpinning actions. Adult endoscopy - 3rd party provider in place. Long term workforce plan with recruitment in progress. Capital work to support JAG accreditation, completion end of December, and decant to TGH site. RMCH endoscopy - long term workforce plan in place, 2 substantive consultants has been recruited commencing in post in July and November. Additional sessions being undertaken in the interim. Paediatric MR - additional anaesthetic sessions secured from the end of August onwards. 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 plans. Business case for the 3rd MRI scanner approved Participation in GM Task ad Finish group focused on diagnostics.	Clinical Services	Q3 2017	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.

Principal Risk: If the organisation does not achieve Cancer Waiting Time Targets, Improve Patient Experience & Clinical Outcomes			Enabling Strategy: Performance Management			Associated Committee: Quality & Performance Scrutiny		
			Lead Director: Chief Operating Officer			Operational Lead: Director of Corporate Resilience		

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. Escalation process in place to ensure timely action of patients along the pathway. GM Cancer Access Policy in place. Trust Capacity Group to receive risk assessment/capacity plans for national cancer campaigns to mitigate demand increases.	16 4x4	1. Pathway management across multiple Trusts. 2. Patient choice 3. demand in excess of planned levels	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 meeting with high risk cancer sites. Trust compliant with the 10 High Impact Actions for Cancer	Clinical Divisions, Corporate Performance Team	End of 2017	Cancer Committee	Delivery of Cancer Standards	Continued growth in demand experienced during Q1 Wythenshawe site continue to have strong performance against the 62 day standard. Central/TGH sites are challenged with performance static at 79% Improvement in September seen against the 2ww standard

Principal Risk: If the challenges on midwifery recruitment continue, the obstetric medical rota is not covered and high demand on obstetric beds continues then quality and safety of care may be compromised. Obstetric capacity (Risk 4446)	Enabling Strategy: Maternity Capacity Strategy; Recruitment Work Programme	Associated Committee: Quality & Performance Scrutiny Committee; Human Resources Scrutiny Committee
	Lead Director: Chief Operating Officer	Operational Lead: St Marys Hospital CEO

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	Failure to recruit midwives in line with turnover and maternity leave Failure to operate compliant junior medical staff rotas due to vacancies, maternity leave and workload Inability to admit women to the maternity unit due to the demand on obstetric beds	05/08/2016 • Monies for 27wte midwives (was 34wte), In reach Team and two Clinical Fellows has been identified and agreed. New obstetric rota in place as from the beginning of August. • In reach team SHO (1.50wte) appointed to commence in august and 1wte nurse commence in June and remaining 1.60wte to commence in September. Plan to go out to advert again for midwives due to the number of vacancies (44.90wte out of midwifery establishment of 342.55wte. • Proactive Recruitment Campaign including open days and the 'Proud to Care' campaign • Employment of additional Clinical Research Fellows • programme to support neonatal locum shifts until March 2016 • two locum consultants appointed • reconfiguration of gynaecology & obstetric theatre lists to create capacity to enable additional elective caesarean section • work stream commenced, led by a Consultant and Lead Midwives, to review the overall elective pathway in obstetrics for intrapartum care • recruitment to the in-reach team to reduce length of stay on the postnatal wards	15 5x3	Increase in births and increased complexity of the women being cared for in Saint Mary's maternity unit has resulted in occasions where there has been insufficient bed capacity Confirmation of revised escalation and divert policy	lead in time for recruitment of midwives • Recruitment of junior doctors in neonatology to provide care on the postnatal wards may not be in place before August 2016	Discussion with NHSE and commissioners to consider controls in place to support women in their choice of place of birth • Increase the funded establishment • Use of IT to optimise efficiencies Transformation programme • Open day held for midwives in April 2016 potential recruitment of 50wte midwives by Q3	The Obstetric capacity and demand strategy presented to the Executive Director Team and approved in November 2015 • Funding supported Open recruitment planned day for 06/05/2017 Midwifery staffing was 328.05 and vacancies were 13.79 end of March. For Q4 the average maternity leave rate was 24.91. Sickness in march was 3.9% Induction of labour pathways: audit in progress re consultant making re induction and 2 IQP work stream re delays on transfer from ward 56 to delivery unit and allocation of 2 midwives on DU to care forth induction transfers.	9 3x3

Risk Reduction Plan

Key Actions	Responsibility		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Midwifery Recruitment	DDoN/HOM	On-going	Obstetric Business Meeting	Funded Establishment increased to 342.50 wte		Obstetric Business Meeting
Neonatal Junior Doctor Recruitment	DM NICU	Complete	NICU Business Meeting	Funded Establishment increased by 1.5 wte		NICU Business Meeting
Inreach Team Nurse Recruitment	DM NICU	Complete	NICU Business Meeting	Funded Establishment increased by 3.0 wte		NICU Business Meeting
Review of elective Pathway in Obstetrics	DM Obstetrics	On-going	Obstetric Business Meeting	Revised Pathway in place and improved patient flow		Obstetric Business Meeting
Agree Divert Policy within GM	DDoN/HOM	Complete	Obstetric Business Meeting	Effective Policy in place suitable for maternity units		Obstetric Business Meeting

Principal Risk: If there is a failure to deliver the Medical Workforce Projects then quality and safety of care and finaical turnaround may be compromised.			Enabling Strategy				Associated Committee	
							HR Scrutiny Committee	
			Lead Director				Operational Lead	
			Medical Director				Programme Director Medical Workforce Projects	
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. Appointment of a Programme Director 2. Appointment of a project team 3. Other organisational governance structures 4. Medical Workforce Projects Risk/ Issues Log 5. Stakeholder Engagement Strategy/ Comms Plan 6. Overarching Programme Plan - all MW Projects 7. Job Planning Tool implementation and outputs 8. Job Planning Project Plan 9. Out of Hours Project Plan 10. 7DS Project Plan 11. HR Scrutiny Committee oversight 12. LNC liaison 13. Team Action Plan 14. Internal Locum Dashboard 15. Finance Agency Reports 16. WAVE monitoring 17. NHS I Weekly Agency Report	**12** **4x3**	Lack of consistency in approach of Divisions Lack of consistency in approach at regional and national level Lack of engagement from Divisions; and attendance at key meetings Gaps in organisational completion and approval of Job Plans Lack of 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 Divisions Regular updating of WAVE not yet consistent No prompts in the paper patient record - EPR would resolve this (7DS)	Assurance that key information is cascaded appropriately within Divisions (e.g. from DDs and CHDs down) Changes to NHS Improvement weekly reports on Agency Cap breaches Robustness of Job Planning Tool and ensuing reports Gaps in assessment of full impact of IR35 Difficult to qualify/ quantify impact of Medical Workforce projects on Turnaround	OMG Reporting Regular updates to Medical Director and Executive Director of Human and Corporate Resources HR Scrutiny Committee progress reports NHSE Monitoring Reports Fortnightly meetings Turnaround Coordinator Turnaround Control Group Medical Director, Executive Director of Human and Corporate Resources, and Programme Director meetings with Divisions (CHDs, DDs, HR BPs and Finance) three times a year	Steady progress to 100% Consultant Job Plans available via Job Planning tool Reducing Locum/ Agency Spend Visible improvement in each 7DS Self Assessment Survey cycle (currently Spring)	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome
Complete self assessment on 7DS 4 priority standards	Divisions, supported by Cameron Chandler	Q1		- Spring 7DS self assessment is in line with NHS Improvement and NHS England timeframes - rating of green
Establish Trust-wide RAG rating on 6 remaining 7DS Standards	Divisions, supported by Cameron Chandler			
Develop/ relaunch key forms and processes relating to Medical Workforce - Sickness absence - Annual Leave - Study Leave - Agency Approval process for high rate agency payments (New) - Ward Rounds (New)	Jill Alexander Rachel Jenner, MWP Team Rachel Jenner, MWP Team Vicki Hall Rachel Jenner, TGH Ortho	Q1		- Defined forms and processes are available to underpin key Medical Workforce developments - Divisions are engaged and feel well supported
Regular communications to Divisions in line with the Stakeholder Engagement Strategy: - Updates to intranet site (news and resources) - Offer support to Divisions in development of project plans and task lists - Provide training (Job Planning Tool; Team Job Planning)	Laura Herbert Laura Herbert Alison Wake/ Ash Sukthankar Jill Alexander, Ash Sukthankar	Ongoing Ongoing Q1 Q1	-OMG - HR Scrutiny Committee -Turnaround Control Group	- All Consultant Job Plans are input to the Job Planning Tool; and approved - Divisions are engaged in Team Job Planning; and can use reports produced by the Job Planning Tool to inform changes and improvements for the next Job Planning cycle
Meet with CHDs and DDs to progress input of Job Plans; and set expectations for next job planning cycle	Divisions	Q1	-Quality and Performance Scrutiny Committee	
Implement sanctions for continued non-compliance re input of job plans and appraisals; and communicate to Divisions	Laura Herbert	Q1	-Board of Directors	- Job Plans underpin activity and workforce planning
Offer support to Divisions for input to and monitoring of WAVE	Laura Herbert	Ongoing	-TMB	- WAVE is well utilised - KPIs are captured, milestones are added and regularly updated
Establish regular meetings with project leads: - Job Planning - Locum/ Agency Spend	Laura Herbert/ Alison Wake Laura Herbert/ Vicki Hall	Q1		- MRI has fully trialled a new model of Out of Hours service provision, and has developed a Business Case based on the outcomes
Provide regular job plan status reports to Divisions	Cameron Chandler	Ongoing		
Support Divisions to generate reports from Job Planning tool and understand/ interpret the contents (e.g. inconsistencies, outliers)	Alison Wake/ Ash Sukthankar	Q1		
Provide project management support to Out of Hours (MRI) - Planning, trialling OOH model; evaluating outcomes; development of Business Case	Laura Herbert/ Alison Wake	Q1/2		

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 and 5739U)			Enabling Strategy			Associated Committee	
			Performance Management			Quality & Performance Scrutiny	
			Lead Director			Operational Lead	
			Chief Operating Officer			Director of Corporate Resilience	

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	12 4x3	Commissioner decisions around alternate providers	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. Delivery of Divisional transformation and capacity plans. Hospital Site performance meetings continue to ensure the effective management of waiting times. Use of the private sector, in particular at Wythenshawe site to underpin delivery of recovery trajectory Development of a single Patient Access Policy for MFT Participation in GM master classes for RTT	Hospital Sites	On-going	Quality & Performance Scrutiny	Activity Levels Delivered and Waiting times improve	Central/TGH sites have strong track record of achievement of the standard, although underperformance at RMCH, St Marys and TGH sites. Wythenshawe - underachieved the standard throughout 2016/2017, in July and August performance below the recovery trajectory.

Principal Risk: If appropriate safeguarding systems and processes are not in place then vulnerable Adults & Children may not be safeguarded from harm	Enabling Strategy	Associated Committee
	Safeguarding Strategy	Safeguarding Committee
	Lead Director	Operational Lead
	Chief Nurse	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
15 5x3	Vulnerable adults and children may come to harm	1. Safeguarding Governance Structures 2. Safeguarding policies and procedures. 3. Safeguarding Team 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 on Bedman to alert LD Specialist Nurse to review patient. 8. Divisional assurance process 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 vulnerable patients and clients are protected. 11. Reports provided to statutory meetings if staff are unable to attend.	**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 divisions achieve full compliance with required training attendance 4. Limited LD specialist nurse capacity and no provision to cover leave. 5. Insufficient capacity in School Nursing Service to meet statutory requirements to attend all strategy meetings and case conferences	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.	1. Incident Data. 2.Training attendance data demonstrates compliance with level 1 children's safeguarding training. 3. Quality Review Information. 4. DoLS/MCA Assessment Records. 5. Audit Outcomes. 6. External Review (Ofsted/CQC inspection, Section 11 Audit, CCG review of safeguarding and LAC provision) 7. Case conference/strategy meeting attendance records	1. Annual Safeguarding Report to Board of Directors. 2. Service work plans - monitored by the Trust Safeguarding Group. 3. Divisional Safeguarding Assurance meetings re: compliance with CQC regulations with NED with safeguarding lead, Safeguarding Lead Director and Head of Safeguarding - reported to the Safeguarding Effectiveness Committee 4. Completion of SCR actions - reported to the Trust Safeguarding Group 5. Section 11 audit - Reported to the Safeguarding Effectiveness Committee. 6. Annual Safeguarding Work Programme, monitored by Trust Safeguarding Group and reported to Safeguarding Effectiveness Committee	**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 vulnerable people	Safeguarding work programme on track. Lack of School Health capacity to attend all case conferences/strategy meetings raised with Director of Public Health as commissioner of the service and additional funding agreed - recruitment underway and making positive progress with over 8wte school nurses recruited. Delays in Best Interest assessment and DoLS authorisation raised with Strategic Director of Adult Social Care - January 2017. 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. New FGM training rolled out. New DoLS /MCA training rolled out. All policies updated to reflect new legislation and multi agency strategic plans Divisional Safeguarding Assurance meetings to commence in May 2017

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	Associated Committee
	Nursing and Midwifery Retention Strategy and Recruitment Work Programme	Nursing and Midwifery Professional Forum and Human Resources Scrutiny Committee
	Lead Director	Operational Lead
	Chief Nurse	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 Resources to manage volume of recruitment for nursing and midwifery in timely manner Embedding use of E roster and safe care in real time within all clinical areas. Regulatory changes to English language requirements for EU nurses will 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. 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 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) E Rostering and Safe care module used effectively by all wards and departments Development of new roles to support nursing workforce - housekeeper, ward assistant. theatre scrub assistant 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 Management Board, HR Scrutiny Committee, Risk Management Committee, OMG 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 17% (August 2015) to 11.7% (March 2017). It is predicted that the vacancy rate will increase slightly in Q1-2 whilst waiting staff to complete programmes of training but the predicted position in September 2017 is anticipated to be 8.7 %. Reduction in staff nurse (band 5) turnover since launch of Retention Strategy and work programme to 18.9% from 19.9% in July 2016. Nursing and Midwifery Workforce Development Group established in October 2015 which focuses on development of new roles supported by competency frameworks to support registered workforce gaps (i.e. pharmacy technician role, theatre assistant practitioner role, ward assistants role, etc.). This group has resulted in the implementation of a theatre scrub assistant (band 3) role and Pharmacy Technician role. The Trust is part of GM pilot for trainee nursing associate roles with 68 candidates offered posts commenced their training on 30th January 2017 Divisional sickness/absence reduction trajectories established with associated WAVE scheme.	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	Apr-17	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 Compliance With Healthcare Quality National Regulatory Requirements is not achieved this could impact negatively on patient outcomes, experience and reputation(2379)			Enabling Strategy			Associated Committee		
			Quality Strategy / OD&T Strategy / Transformation Strategy			Quality and Safety Committee		
			Lead Director			Operational Lead		
			Medical Director / Chief Nurse			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 Reputational impact Associated business continuity	Organisational Governance Structure Quality Review Programme Organisational self assessment 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	Clinical Standards Committee Clinical Effectiveness Committee Trust Risk Management Committee Board Assurance Framework Board of Directors Reports Internal Audit Patient and Staff surveys External Visit Data Quality Review Reports CQC internal monitoring IQP data Consultant metrics	CQC Comprehensive Inspection Report Nov 15 Quality Review reports 2016 Deanery and GMC training survey CQC Insight Report Sept 2017	9 3x3

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Quality Reviews undertaken to follow up on action plan Results now shared and action plan underway				Movement to a CQC rating of 'outstanding' across all services	Good progress.

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

Principal Risk: If we do not comply with building regulations - Fire Stopping and Fire Doors this 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 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 an operational area and potential impact for harm to staff, patient of public	24/7 monitoring of the fire alarm system and L1 fire alarm system in key areas allowing early warning. Remaining areas have L4 system (detection in corridors and escape routes). Fire service attend all incidents on "blues and twos" ie no call filtering or delay system in place with attendance within 5 minutes Fire wardens trained for each ward/dept and fire risk assessments undertaken for all properties and an action plan in place for all identified issues. Weekly checks of fire safety provisions within each ward/dept by fire wardens and evacuation risk assessments in place for wards/depts External expert assessment completed to review whether further mitigation measures required and appropriate actions taken	15 3x5	Most controls are reactionary, based on minimising impact should a fire occur	Time taken to complete survey & remedial works	Ongoing survey reports reduce level of unquantified risk and support that adequate controls are in place. Expert analysis of risk as developed through Trust expert survey team further supports 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 Srategy Board	Survey work completed & remediation carried out	Survey and remediation work on track

Principal Risk: If there are insufficient trained mental health support this could impact negatively on patient outcomes and experience (Risk 4140C)			Enabling Strategy: Quality Strategy			Associated Committee: Clinical Effectiveness Committee	
			Lead Director: Medical Director			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	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 to formalise arrangements. Support funded and recruited to maintain progress in year.	Sarah Corcoran	Mar-18	CEC	Support available to patients and staff when needed	Meeting held with the Mental Health Trust, assistance requested from the CCG.

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			Associated Committee: Adult Palliative and End of Life Group Babies, Children and Young Person Palliative and End of Life Group	
			Lead Director: Chief Nurse			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	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	Progress mede in terms of work programmes in line with expected delivery dates.

Principal Risk: If we do not maintain safe staffing levels this may impact negatively on staff health and wellbeing and our ability to deliver safe, clinically effective care Links to : (detail provided against key priority-Developing, Maintaining And Consistently Deploying Nursing And Midwifery Establishments,			Enabling Strategy Nursing and Midwifery Retention Strategy 2015-2016 Lead Director Chief Nurse			Associated Committee Human Resource Scrunity 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	Failure to deliver the planned nursing establishment through these programmes of work will impact on our ability to deliver safe, clinically effective care Impact on the delivery of the Trust principle objectives	Ward and department establishments approved by Directors of Nursing and Chief Nurse ● Nursing and Midwifery Staffing esculation processes in place ● E Roster system utilised to enable the appropriate and effective use of staffing resource. ● Bi annual acuity and dependency census reviews for in patient ward areas using the Safer Nursing Care Tool (SCNT) ● Duty rostering guidelines aligned to e-rostering system ● Daily review of ward staffing by matrons/lead nurse● Wards/departments display planned and actual staffing for at entrances to clincial areas ● Weekly bank and agency ustilisation meetings within each division ● Nursing and Midwifery Retention Strategy and work programme under pinned by divisional work programmes ● Annual recruitment plan aligned to workforce supply ● Attendance at Unversity careers days ● Return to practice programmes provided annually ● Trust Preceptorship Policy ● Practice Education infrastruture to ensure provision of quality educational placements ● Effective temporary staffing supply process with NHS Professionals as partner ● non EU international programme of recruitment ● Nursing and Midwifery recruitment meetings held monthly to oversee recruitment process ● Directors of Nursing Preceptership listening events held for all new qualfied nurses ● Nursing associates operational group established to support the development and intergration of Nursing associate role in trust	9 3x3	Current recruitment process provided limited assessment for values and bahaviours Embedding use of E roster and Safecare in real time within all clinical areas.	Ability to reduce number of vacancies against the national workforce supply	Recruitment campaigns result in substantive appointments ● On target for progress against recruitment, retention and attendance plans ● Regular reports from recruitment management system to identify delays in process and enable actions to be taken ● Reduced turnover in band 5 roles ● Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) ● E Rostering and Safecare module used effictively by all wards and departments ● Development of new roles to support nursing workforce	Bi annual Safer Staffing reports to Board of Directors ● Regular staffing position reports to Trust committees ● Establishments reviewed as part of annual budget setting process or when any significant changes in service or patient cohort ● Acuity and dependency monitoring undertaken monthly in all areas where validated tool is available ● Recruitment and retentions schemes have resulted in reduction in vacancy rate for band 5 roles from 17% (August 2015) to 11.7% (March 2017) ● Reduction in staff nurse (band 5) turnover ● Intrroduction of trainee Nursing associate role from January 2017	9 3x3

Risk Reduction Plan					
Key Actions	**Responsibility**	**When**	**Monitoring Committee**	**Planned Outcome**	**Progress Evaluation**
Delivery of nursing and midwifery recruitment plans and retention strategy.	Directors of Nursing	Mar-18	Trust Management Board	Achieve reduction in vacancies and imporve retention at all levels	Monthly

Principal Risk: If we do not meet patients food, nutrition and dining needs this will impact negatively on patient experience and outcomes			Enabling Strategy Quality Strategy Lead Director Chief Nurse			Associated Committee Quality 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**
20 5x4	Reduced quality of patient experience and outcomes, and adverse impact on the Trust's compliance with food and nutrition regulatory standards.	1. Environment of Care Group supported by relevant expert groups oversees delivery of work programme and monitors impact through patient feedback mechanisms. 2. Annual Perfect Dining Week 3. Contract monitoring focused on patient experience outcomes. 4. Protected meal times relaunched.	10 5x2	Variable compliance with relevant procedures	Not all wards able to provide evidence of quality improvement.	1. Reports to Quality Committee 2. Performance reporting to BoD. 3. Patient survey results. 4. Quality Care Rounds and Patient Expereince Tracker data. 5. Joint audits of compliance with standards with Sodexo 6. Accreditation outcomes	1. Patient feedback above agreed threshold (>85%) across quality indicators.	10 5x2

Risk Reduction Plan					
Key Actions	**Responsibility**	**When**	**Monitoring Committee**	**Planned Outcome**	**Progress Evaluation**
Deliver enviroment of care work programme	Debbie Armstrong	Jun-17	Quality Committee	Consistently meet patients food, nutrition and dining needs to a high standard.	Work Programme on track other than work with Shelford Group, which commenced in April 2017 and is on-going. Work commenced with Director of Estates and Facilities to ensure FM contract management focuses on patient experience. Patient Experience Tracker metric for satisfaction with food for 2016/17 is 85.9%

Principal Risk: If we fail to implement the actions arising from the National Patient Survey this could impact negatively on patient experience and reputation			Enabling Strategy: Quality Strategy			Associated Committee: Quality Committee		
			Lead Director: Chief Nurse			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**
12 3x4	Adverse patient experience damage to the Trust reputation High	1. Corporate and divisional Quality governance and delivery strutures addressing all patient survey & feedback responses 2. Monitoring systems in place for complaints, concerns and compliments. 3. Revised Complaints Policy and processes in place. 4. Complaints management guidance provided to Divisions - January 2017 5. Internal patient feedback collection mechanisms in place. 6. Improving Quality Programme in place across the Trust 7. Patient Experience programme launched in November 2016.	9 3x3	1. Data systems for collection and management of patient experience feedback require updating but not included in capital programme agreed by Informatics Strategy Board. 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. Governors' Patient Experience working group receive reports on progress. 2. Reports to Quality Committee on improvement work to address aspects of national patient surveys. 3. Reports to Quality Committee, TMB, QPSC, OMG and Board of Directors on progress of patient experience programme. 4. Outcomes of the Quality Reviews reported to Board of Directors. 5. Harm free care data monitored and exceptions reported to Nursing and Midwifery Professional Forum 6.Reports to Quality Committee and Board of Directors on progress and results of Accreditation Programme	1. Improvements in care evident from Quality Care Rounds and Patient Experience Tracker data. Overall Quality Score 95% and 89.6% respectively (2016/2017). 2. Ward accreditation outcomes - 29 (36%) Gold Areas (2016/17) 3. Complaints KPI meeting chaired by Chief Nurse - reduction in over 41 day complaints	6 3x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Embed new Patient Experience Framework Refresh Brilliant Basics Programme to align with new Patient Experience Framework Deliver Perfect Dining Week Action Plan	Divisional Directors Director of Nursing Sue Ward/ Deputy Director of Nursing Debbie Armstrong	Sep-17	Quality Committee	Improve areas of patient experience that consistently score below average in national patient surveys	Good engagement with, and spread of new approach to patient experience - What Matters to Me from staff and patients. Ongoing improvement plan for food and nutrition informed by the outcome of the "Perfect Dining" week.

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			Associated Committee: Transformation Operational Board		
			Lead Director: Chief Operating Officer			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**
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	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	Operational Lead(s)
	Chief Finance Officer	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	- Continuing to build on improvements in monthly run rates - Plans established and signed off with all Divisions to identify an expected level of performance against budget, including where necessary, a 'control total' for partial recovery of accumulated budget deficit where full recovery is not judged to be realisitc within the 12 month period. Regular Divisional run-rate meetings in place across run rate delivery programmes led by Executive Directors - Progress towards financial sustainability is reviewed and challenged in , Division-specific financial delivery progress review meetings led by the Chief Finance Officer and the Chief Operating Officer - Turnaround team challenge at all Divisional tracking meetings - The review and challenge of 2017/18 project forecasts for all existing plans, supported by formal sign-up and scrutinised delivery across all newly identified projects - Progress against financial sustainability target and trajectories routinely reported to Board of Directors and in detail to the Finance Scrutiny Committee - An extensive, system-driven framework of tightened tolerance thresholds for non-pay authorisation is in place - Regular update of projects on WAVE with Divisional Director sign-off - The weekly tracking and reporting to the Turnaround Team on progress against milestones and non-financial KPI, together with reasons and remedial actions identified to deal with any project slippage	20 5x4	None	None	Through the monthly Financial Delivery Progress Review meetings, the discipline of quarterly rolling forecasts has been established. When these forecasts have been sufficiently challenged and assured in relation to the degree of stretch built into them, then the measurement of delivery against trajectory month by month in each subsequent quarter will provide assurance of recovery of Divisional positions towards fully achieving the agreed budgetary control totals.	● An extensive framework of review, challenge and escalation is fully embedded within the organisation ● The current trading positions of both existing Trusts continue 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.	Divisional Ledership Teams	Monthly	Finance Scrutiny Committee	-	-

Principal Risk: Delay in implementation of Informatics Strategy due to cultural, behavioural and changing landscape.			Enabling Strategy			Associated Committee		
			New Strategy to be confirmed.			Informatics Strategy Board		
			Lead Director			Operational Lead		
			Alison Dailly			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**
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 Operational 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	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	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: 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 interst of individual organiusations.			Enabling Strategy			Associated Committee		
			TBC			TBC		
			Lead Director			Operational Lead		
			TBC			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 single 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	**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 key specialties GM model for benign urology aligns with MFT model	MFT lead transformation provider for paeds, breast surgery, vascular services MFT (Wythenshawe) designated lead provider for urology cancer surgery	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation

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			
			TBC		SHS Programme Board			
			Lead Director		Operational Lead			
			Director of Strategy		Associate Director 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	3 3x1		History of failed attempts at collaboration. No routine mechanism to assess attitude to merger	Increased collaboration in interim (as allowed by CMA) Establishment of SHS single services Lessons learned from previous service mergers Result of staff questionnaire on attitude to merger	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)	3 3x1

Clinical engagement in design of new organisational arrangements

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Analysis of results of questionnaire issued to all staff to assess attitude to merger		Mar-17	SHS Programme Board	Better understanding of clinical staff attitude to merger	On going

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:**		
			-			-		
			Lead Director:			**Operational Lead:**		
			Medical Director			Graeme Black /Karen Connolly		
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	**9** **3x3**	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
Strengthen genomic medicine centre capability and research quality	Graeme Black	Q1 - Q3	Divisional Management Board - SMH and R&I	Secure designation as one of 8 national clinical genomics hub centre with NHS/Genetics England.	Monthly reporting from Trust Management Board

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**	**Associated Committee**
	OD Strategy	HR Scrutiny Committee
	Lead Director	**Operational Lead**
	Executive Director of HR and OD	Associate Director of OD &T

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	Associate Director of OD&T lead and set clear objectives for OD&T managers Divisional Business Plans include a local People Strategy Leadership Competency framework in place Appraisal policy in place and quality standards monitired service level Workforce Plans in place HRBP Model in place to support local Managers and Leaders. People Management Skills programme in place Approved ED&I strategy in place with annual delivery plan	**9** **3x3**	1. No Leadership and Culture strategy 2. No Systematic Values Based Recruitment process 3. No non-pay budget for OD programme 4. No Talent Management and succession plans 5. No funded OD plan for delivering strategic change programme	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.Cultural assessments reported to Quality Committee and HR Scrutiny Committee 2. Quality Reviews reported to Quality Commitee and Clinical Effectiveness Committee 3. Divisional Review process 4 Medical leadership and engagement in divisional business/transformation reported to HR Scrutiny Committee 5. Leadership development outputs reported to HR Scrutiny	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 Operational Committee 6. 90% compliance with Clinical Mandatory training 7. 90% compliance with Corporate Mandatory	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Committee	Planned Outcome	Progress Evaluation
1 Complete Phase 2 of NHS Improvement Culture Programme to develop Leadership and Culture Strategy 2. Secure investment from Locality Transformation fund to implement Locality OD Plan 3. Implement actions arising from 2016 staff survey 4. Continue development and embedding of values and behaviours in line with culture programme and SHS plans 5. Continue quarterly pulse checks to monitor staff experience 6 Expand delivery of VBR incrementally within current capacity and capability 7 Support Divisions with the implementation of staff engagement and medical engagement programmes 8. OD& T Business Plan 2017-18 9. Develop Leadership & Culture Strategy	HR/OD&T	Mar-18	HR Scrutiny Committee	Maintain the 16/17 response rate to Staff Survey Staff engagement score achieved within the top 20% Number of key findings in the staff satisfaction survey scoring in the top 20% increased	• Phase 1 of the culture programme has been completed resulting in a toolkit that includes 6 resources for diagnosing organisational culture. • Cultural diagnostic with UHSM completed • Phase 2 of the Culture programme pilot is underway• Staff survey actions being implemented to achieve this year's goals • Staff engagement activities ongoing across every Division and measured through quarterly pulse checks : OD&T business plan and end of year progress report completed : Some Locality funding secured: Leadership & Culture Strategy drafted

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 HR & OD			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**
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 diffucult 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	**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. Apprenticship strategy (in development) 6. 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. Accurate finance plan for Apprenticeships and levy spend	1. Cross professional learning and education monitored and reported to HR Scrutiny Committee via the Strategic Workforce and Education Committee 2. Apprenticeship programme monitoterd and reported to the Apprenticeship Steering Group and into SWEC 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 engagment 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 local strategy • Deliver actions set out in the Talent for Care strategy • Develop a SHS 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 in the Divisions and the Education Department • Develop action plans to address concerns identified as a result of the monitoring visit undertaken by HEENW in March 2017 • 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-17	Strategic 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. • Guaranteed interviews after pre-employment training resulted in 80% of applicants being successful • Launched the GM Careers Hub in 2016 • Apprenticeship programme now expanded to include A&C Apprenticeships • All potential apprentiship opportunities being scoped out via the Apprenticeship Steering Group • Talent for Care strategy actions implemented including improving learner facilities • Learning & Education startegy being developed from a Single Hospital perspective • Mandatory training compliance meeting / exceeding target

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 Medical Director			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**
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 Comparison of reference cost, the results of which are signed off by the	Feedback from yearly Student survey undertaken by the University, the results of which are sent to the Medical Director. Success rates for Medical exams - (94.8% in 15/16)	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Explore further options to reduce the cost of	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	Initial discussion with Head of Medical
Explore possibility of increasing the number	G Terriere	Jun-17	Turnaround	Increased student weeks and income	

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: ED&I Strategy			Associated Committee: HR Scruntiny Committee/Quality Committee		
			Lead Director: Executive Director of HR & OD			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**
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			Associated Committee: HR Scrutiny Committee		
			Lead Director: Executive Director of HR and OD			Operational Lead: Director of Operational HR		
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 supported by detailed HR work plan for 2017/18 that is reviewed on a quarterly basis. Underpinned by KPI's that are reported monthly to TMB and BoD • Comprehensive Divisional workforce plans aligned to Business plans and the People Strategy. • Executive scrutiny of vacancy levels, corporate 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. Shine Brighter careers website. Consultant recruitment campaigns for hard to fill posts. • Restructure of HR directorate with strengthened HRBP model in place 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. • 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**	Values based recruitment practice has not been fully introduced with a comprehenisve assessment of values and behaviours against Trust framework at all selection processes. Capacity to deliver buisness as usual and transformational change. Impact of external market forces on hard to fill posts and agency supply. 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** Divisional Reviews with Executive Team. 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. Vacancies reduced to 5% (all staff groups) by March 2018. Time taken to fill vacancies maintained at 65 days during 17/18.. Retention of staff with over 12 months service at more than 80%. 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. 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. Ongoing development of a Careers website with innovative employer branding and candidate engagement for attraction. Delivery of Proud to Care 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