TRUST BOARD PART I – MARCH 2012

Agenda Item Number: 39/12
Enclosure Number: (6)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Sheena King – Head of Risk Management Peter Mellor – Company Secretary Peter Mellor – Company Secretary
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • Top risks • Removal of risks 2.1, 3.2, 3.3, 3.4, 4.1, 5.2, 5.2A, 5.3 and 5.4 • Increase of risk 5.1 to a risk score of 9 • Decrease of risks 1.2 to a risk score of 9, 1.3 to a risk score of 12 and 5.5 to a risk score of 6
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented to Trust Board in April 12.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: March 2012

Purpose:
To provide the Trust Board with an update on the Assurance Framework as of 20 March 2012

Top Risks

6.2 ◄► **(16):** The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration

New Risks

Nil

Risks with an Increased Score

5.1 ▲ **(Yellow 6 to Amber 9):** The Trust breaches emergency department quality standard key targets – A & E Timeliness - Increase of 9% to predicted demand

Risks with a Decreased Score

1.2 ▼ **(Amber 12 to Amber 9):** Inability to maintain ongoing compliance with all CQC standards – report from recent CQC responsive review shows improvement with compliance

1.3 ▼ **(Red 16 to Amber 12):** Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, identified at or more than 72 hours of admission – currently under trajectory

5.5 ▼ **(Amber 9 to Yellow 6):** The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit – significant and sustained improvement in percentage of direct admissions.

Risks to be Removed

2.1 ▼ **(10):** Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP – service to remain.

3.2, 3.3, 3.4, 4.1 – to be removed and re-described to be in line with and reflect the new workforce strategy.

5.2, 5.2A, 5.3, 5.4 – to be removed, targets achieved, risks to be replaced by those identified that threaten 2012/13 operational requirements.

Prepared by: Sheena King – Head of Risk Management & Legal Services

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2011/12 – PROGRESS SUMMARY – MARCH 2011

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	
1. To provide best care as measured by clinical effectiveness, safety and patient experience (JD/SH)	FMcN (G&C)	1.2	Inability to maintain ongoing compliance with all CQC standards	ALL	12	9	12	12	9								6 Jun 12
	CM (ICMC)	1.3	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, identified at or more than 72 hours of admission	8	16	16	16	16	12								4 Apr 12
	SB (SPSSG)	1.4	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	16	9	9	9	9	9								3 May 12
2. To be the hospital of choice for patients (JD/SH)	SW (EMT)	2.1	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP.	13	15	15	15	10	**To be Removed**								10 Apr 12
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (TP)	PG (SMT)	3.2	Inability to achieve and maintain Trust target of 85% compliance with statutory and mandatory training requirements by Q4 2011/12	14	6	9	9	9	**To be removed and re-described**								3 Mar 12
	TP (SPSSG)	3.3	Failure to engage all staff in the PHT *'Bringing Values to Life'* campaign	16	6	6	6	6	**To be removed and re-described**								3 Jul 12
	TP (SSCSG)	3.4	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	14	9	9	9	9	**To be removed and re-described**								6 Jan 12
4. To be the employer of choice in South East Hampshire (TP)	TP (SMT)	4.1	Inability to attract the best staff to PHT, and continue to engage and motivate our current staff will compromise our ability to offer the best care	13	4	4	4	4	**To be removed and re-described**								1 Jan 12
5. Be in the top quartile of NHS hospitals for 95% of all services we provide (CW)	CW (SMT)	5.1	The Trust breaches emergency department quality standard key targets – A & E Timeliness	4	6	6	6	6	9								3 Mar 12
	CW (SMT)	5.2	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	4	9	9	9	3	**To be Removed**								3 Mar 12
	CW (SMT)	5.2A	The Trust fails to achieve the required referral to treatment targets for non-admitted patients and reduce the 18 week admitted backlog.	4		9	9	3	**To be Removed**								3 Mar 12
	CW (SMT)	5.3	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required	4	6	6	6	3	**To be Removed**								3 Mar 12

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	
			level														
	CW (SMT)	5.4	The Trust breaches required cancer referral/screening to treatment standards.	4	3	3	3	3	To be Removed								3 Mar 12
	CW (SMT)	5.5	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4	9	9	9	9	6								3 Mar 12
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money (RT)	SG (FC)	6.2	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration	26	20	16	16	16	16								8 Mar 12
	SG (FC)	6.3	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26	16	16	12	12	12								8 Mar 12
	SG (FC)	6.4	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients	26	12	12	12	12	12								8 Mar 12
	DH (FC)	6.5	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status	26	16	16	8	8	8								8 Mar 12

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE Responsible Executive: Director of Nursing/Medical Director												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress	
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C x L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target		
1.2 (All)	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Feb 10) • Accepted for CQC registration without conditions 2010/11 • CSC risk registers • Mock CSC assessments and associated action plans • Monitor Quality Risk Profile monthly • Quarterly evidence and action plan review panels established including NED • CQC awareness sessions • Trust wide action plans for medicines management and privacy and dignity • Action plan to address minor concerns for ongoing compliance with outcome 1 and 5	• Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Mock CSC assessments • Outcome of second quarterly evidence review panels show continued improvement in outcome focused evidence • Internal CQC audit (Deloitte) Apr 11, demonstrating substantial assurance. • CQC Jul 11 report for Outcome 1 (privacy & Dignity) and Outcome 5 (Nutrition) demonstrates overall compliance • Compliance audits	12 (3x4) FMcN G&Q	9 (3x3)	6 (3x2)	• None	• Outcome 9 is now deemed to be compliant. • Follow-up responsive review on 3rd and 4th January. Draft report received: complaint with outcomes 1 and 9, minor concerns with outcomes 4 and 5 and moderate concern with outcome 21. Action plans submitted to CQC.	New process to commence at next panel in February 12 3 remaining actions related to management of medicines – on target to be closed end of March 12 For ongoing monitoring until all actions complete – Action plan complete. Compliance declared internally for Q3 and Jan 12. CQC inspection declared compliance with outcome 9. GA: continue weekly review to monitor completion of action plan. GA: action plan to be monitored monthly by Governance and Quality Committee	Feb 12 Complete Mar 12 Complete Ongoing Complete Complete ~~Mar 12~~ Jun 12	Review ~~Feb 12~~ Jun 12	

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
1.3 (8)	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, at or more than 72 hours of admission, thus prejudicing Trust's compliance to the Health & Social Care Act, Outcome 8 of CQC registration and overall Trust CQC registration. This may result in poor patient outcomes – including safety, experience and consequently damage to Trust reputation	• C.Diff reduction action plan • All emergency corridor patients with diarrhoea tested for C. Diff • Weekly C. Diff MDT ward rounds • Daily review by Infection Prevention & Control team to ensure optimal management of patients with C. Diff • Enhanced cleaning and decontamination of patient environment • Trust wide antimicrobial ward rounds between microbiology and pharmacy • Amber incident investigation for failures to isolate symptomatic patients within 4 hours • Diagnostic testing to identify C.Diff carriers	• Monitoring at ward, CSC and Trust level through clinical dashboards • Monitoring shows currently under trajectory • Isolation of suspected C.Diff patients included in performance indicators at CSC level	16 (4x4) CM ICMC	12 (4x3)	4 (4x1)	• Need to revaluate efficacy of sproacidal agents used in the Trust with a view to improve cleaning • Nurse led cleaning of near patient environment requires improvement • Need to ensure appropriate testing for C. Diff • Need to ensure timely isolation ($\leq$ 4 hours from start of symptoms) • Lack of resource to allow diagnostic C.Diff testing of GP samples	• GDH testing will initially increase number of known C.Diff carriers • Results show an average of 65% of patients not being isolated as required • Growing body of evidence in literature to suggest that hypochlorite may not be the most effective agent available – high ATP scores still being detected from rooms with C.Diff patients • More than 80% of GP samples do not get a C.Diff diagnostic test • Approximately 8% of samples are inappropriate	GC/GA: review meetings plan with Carillion soft FM to trial new cleaning products – trial completed, results being reviewed GC/GA: escalate plans for bed cleaning bureau and equipment library – trial bed cleaning service in operation GC/GA: gain funding from commissioners to accommodate required C.Diff diagnostic testing	~~Jan 12~~ ~~Ongoing~~ Feb 12 Complete Apr 12 Complete	Review Apr 12

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE Responsible Executive: Director of Nursing/Medical Director												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress	
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target		
1.4 (16)	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	• Trust wide action plan • Discharge operational Group	• Not available until national survey results published	9 (3x3) SB SPSS G	9 (3x3)	3 (3x1)	• **None**	• Lack of real time patient feedback • Awaiting final report due Apr 12	GC: complete information prescription pilot for urology, diabetes, respiratory and cancer and evaluate. GA: preliminary report findings show improvement in some areas but not all.	Mar 12 Complete	Review May 12	

STRATEGIC AIM 2: TO BE THE HOSPITAL OF CHOICE FOR PATIENTS
Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO **(CQC Ref)**	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
2.1 (13)	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant impact on level of support to other specialties, detriment to patient experience and increase in required CIP.	• Independent media campaign to retain service • Local council member support	• Referral to Portsmouth & Hampshire Health Overview & Scrutiny Committee	15 (5x3) SW SMT	15 (5x3)	10 (5x2)	• none	• None	GC/GA: three month consultation process commencing January 2012 Risk to be removed		Review Apr 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF

Responsible Executive: Chief Operating Officer

RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**	
3.2 (14)	Inability to achieve and maintain Trust target of 85% compliance with statutory and mandatory training by Q4 2011/12	• Diverse training delivery methods • Robust compliance recording • Increased essential update sessions • Regular performance review of CSC compliance with Trust target • Traffic light reports issued to each CSC identifying staff training requirements • Essential skills training transferred to ESR • Updated MOTs for ESR	• None	6 (3x2) PG SMT	9 (3x3)	3 (3x1)	• Incomplete Trust wide training needs analysis • Departmental staff reductions may impact on ability to meet target dates	• Currently not achieving 2011/12 target	GC: CSCs to review and evaluate job descriptions to identify essential skill needs for each relevant staff group. Learning and Development team to update identified requirements for ESR – 1 CSCs yet to return data. Data inputted to ESR for CSCs and being audited for accuracy GC: South Central SHA standardised learning package to be recommended to Trust Board for acceptance to replace elements of Essential Training and release trainers to focus on priority areas for training. PHT to work with SHA on introducing a Skills Passport which will enable training undertaken in other organisations to be recognised in PHT. Risk to be re-described in line with new workforce strategy	~~Oct 11~~ Feb 12 Feb 12 Apr 12 Apr 12	~~Oct 11~~ Review Mar 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
3.3 (16)	Failure to engage all staff in the Trust *'Bringing Values to Life'* campaign	• Staff and Patient Satisfaction Steering Group (SPSSG) • Communications Strategy • Key communicators in each CSC • Briefing sessions for managers • 'Best People' awards • CEO Weekly Message, Team Brief and Open Forum • 'real time' staff pulse surveys • Team brief cascaded to all staff via line managers • Trust Values DVD	• Increase in staff satisfaction through Pulse surveys	6 (3x2) TP SC SPSSG	6 (3x2)	3 (3x1)	• Four core values not incorporated into all HR policies • Further engagement of staff required • Values not incorporated into recruitment process	• Results of national staff satisfaction survey show improvement but concerns in key areas	GC: agree and introduce 'standard values' paragraph to be included in all HR policies and procedures GC: re write policies and associated documents and introduce values based recruitment GC: introduce values pledge key card - postponed Risk to be re-described in line with new workforce strategy	Jul 12 ~~Nov 11~~ Mar 12	Jul 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
3.4 (14)	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	• Staff Satisfaction Campaign Steering Group (SSCSG) • Improvement plan to address 9 key findings • Individual CSC improvement plans • Agreed establishment with associated recruitment to nursing posts • Staff suggestion scheme – Pound Saving Ideas • CSC employee of the month award • Pulse Survey • CSC leaders recognition and engagement programmes	• Not available until national staff survey results Mar 12	9 (3x3) TP SSC SG	9 (3x3)	6 (3x2)	• Survey results show • The quality of a percentage of appraisal is unsatisfactory • Organisational information is not communicated to all staff • Lack of staff recognition • Lack of engagement with senior leaders	• Pulse survey does not contain all relevant questions • Lack of appraisal quality data	GC: incorporate values into appraisal process GC: ensure use of ESR appraisal template GC: audit the cascade of team brief – included in new pulse survey Nov 11 GC: publicise information to improve work-life balance Trust wide GA: audit of appraisals in each CSC-ongoing Risk to be re-described in line with new workforce strategy	~~Sep 11~~ Dec11 Jan 12 Jan 12 Completed and ongoing Review Jan 12	Review Jan 12

STRATEGIC AIM 4: TO BE THE EMPLOYER OF CHOICE IN SOUTH EAST HAMPSHIRE
Responsible Executive: Director of Human Resources

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO **(CQC Ref)**	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
4.1 (13)	Inability to attract the best staff to the Trust, and continue to engage and motivate our current staff will compromise our ability to offer the best care	• The Values Campaign • Oasis • Family friendly policies • Tax efficient purchase schemes • On site nursery • Childcare vouchers • Staff lottery	• Sickness absence and turnover continue to be below target. • Advertised posts receive high quality applicants	4 (2x2) TP SMT	4 (2x2)	1 (1x1)	• Values not embedded • Values not incorporated into recruitment process	•	GC: bring the Trust values to life to continually improve staff survey results – audit results GC: re-write policies and associated documents and introduce values based recruitment Risk to be re-described in line with new workforce strategy	~~Dec 11~~ Feb 12 Jan 12	Jan 12

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
5.1 (4)	The Trust breaches emergency department quality standards key targets – A & E Timeliness	• Key performance indicators • Patient flow project • Common pathway developed for all patients to achieve rapid assessment and start of treatment	• Monthly COO's Operational Performance Report	9 (3x3) CW SMT	9 (3x3)	3 (3x1)	• Demand has increased by 9% above predicted	• Monthly COO's Operational Performance Report	GA: undertake further audit and monitoring of unscheduled returns in both majors and minors GC: Establish regular meetings with Solent and Southern Health to improve Older Persons Partnership and Out of Hours service		Mar 12
5.2 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	• Key performance indicators • Clinically urgent and MOD patients managed in order of clinical priority • Demand management workstream • Routine patients booked in turn • Additional capacity agreed with PCTs • PCT 'red flag' orthopaedic referrals • PCT contacting patients offering choice of treatment with the ISTC	• Monthly COO's Operational Performance	9 (3x3) CW SMT	3 (3x1)	3 (3x1)	• 18 week backlog impacting on 95th percentile • 18 week backlog impacting on 90% admitted performance	• Monthly COO's Operational Performance Report	GC/GA: activity plan and trajectory in place to clear the admitted backlog, and monitored GC/GA: demand management schemes in place and monitored GC/GA: additional capacity to clear backlog Target achieved, risk to be re-described for 2012/13		Mar 12

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
5.2A (4)	The Trust fails to achieve the required referral to treatment targets for non-admitted patients and reduce the 18 week admitted backlog.	• Hand and foot referrals redirected to other providers by PCT • Additional validation of non-admitted waiting lists • Additional capacity to reduce out-patient waits	• Monthly COO operational performance report to review 95% standard • Weekly waiting list assurance meetings	9 (3x3) CW SMT	3 (3x1) CW	3 (3x1)	• > 18 week out-patient waits impacting on 95th non-admitted performance	• Monthly operational performance report	Target achieved, risk to be re-described for 2012/13		Mar 12
5.3 (4)	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level	• Key performance indicators • Extra manpower sourced for ultrasound demand • Additional screener accredited • Increased colonoscopy capacity	• Monthly COO's Operational Performance Report – reported a decrease in breaches and diagnostic trajectory improvement for Sep 11	9 (3x3) CW SMT	3 (3x1)	3 (3x1)	• Insufficient capacity to reduce non-obstetric ultrasound patient waits	• Monthly COO's Operational Performance Report	Target achieved, risk to be re-described for 2012/13		Mar 12
5.4 (4)	The Trust breaches required cancer referral/screening to treatment standards.	• Key performance indicators • Intensive support • Escalation process • Additional screener accredited	• Monthly COO's Operational Performance Report	9 (3x3) CW SMT	3 (3x1)	3 (3x1)	• Lack of capacity	• Monthly COO's Operational Performance Report	GC/GA: Review of lower GI to be undertaken GGC/GA: new screening requirements may impact on achievement of targets Targets achieved risk to be removed		Mar 12

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE Responsible Executive: Chief Operating Officer												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress		**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**		
5.5 (4)	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	• Key performance indicators • Breach tracking • Agreement with ambulance trust to pre-alert PHT of patient on their way to ED • Escalation process in place for breaches by ambulance Trust	• Monthly COO's Operational Performance Report shows improvement on CT access within 1 hour, CT scan within 24 hours of arrival and high risk TIA patients being seen and treated within 24 hours of first contact.	9 (3x3) CW SMT	6 (3x2)	3 (3x1)	• Not all patients are directly admitted to Stroke Unit	• Monthly COO's Operational Performance Report (shows 88.7% direct admission, target 90%)	Significant and sustained improvement - Breaches now mainly due to asymptomatic presentations			Mar 12

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY Responsible Executive: Director of Finance												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress	
REF. NO **(CQC Ref)**	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any specific **measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**		
6.2 (26)	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration.	• Monthly contract monitoring reports • Information on Referral levels • Monthly contract review meetings • Escalation procedures as outlined in contract • Planned Care and Unscheduled Care Boards schemes to manage risk	• Revised financial recovery plan agreed with PCT's. This has seen an extra £3.7m invested into the contract baseline to recognise the level of activity being performed above plan. • Beyond this the PCTs have agreed to increase the cap by an additional £4m to recognise over performance on Pbr drug exclusions and activity to improve RTT performance	12 (4x3) SG FC	16 (4x4)	8 (4x2)	• Timelag in reporting activity means that monitoring is produced 4 weeks after the event.	• The additional investment of £3.7m together with the increase to the cap of a further £4m has helped to reduce the financial risk to the Trust of activity above plan not being paid for. Despite this there remains a possibility that the Trust will perform a level of activity that still exceeds this new investment plus the revised cap.	GC: work with business intelligence team to try and establish weekly early warning system if activity is moving in the wrong direction GA: The Trust will continue to monitor performance against the revised contract baseline and new cap very closely and continue to flag where work is being done in excess of these levels.	Mar 11 - Review position following January's activity information.	Mar 12	

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY

Responsible Executive: Director of Finance

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	RISK DESCRIPTION (Obstacle to achievement of Strategic Aim)	KEY CONTROLS Any **specific measures** currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C X L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
6.3 (26)	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	• Monthly CSC performance meetings • PMO tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • Turnaround Committee • Sustainability Board	• Monthly reporting to SHA, TB and CSCs • Weekly reporting to TRC • The above shows the Trust has identified plans that amount to its total internal CIP target of £25m except a small shortfall of £91k • Trust is ahead of plan on it's own internal schemes at end of month 9	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• Retrospective analysis of savings assessment could lead to 6-week lag in detection of target failure • Concern remains around the delivery of the £5.5m of savings associated with reduced activity in relation to PCT demand management schemes	• Trust is adrift (£3.8m) of its overall savings target at month 10. This relates to non-delivery of demand management schemes for the year to date which to a large extent will be compensated by additional income for activity above plan.	GC: PMO is encouraging the use of lead indicators and milestones; to enable early warning of plans 'off-track' GC/GA: A system wide recovery plan has been agreed to reduce activity levels part of which is ensuring that existing demand management schemes are delivering (see 6.2 above)	Mar 12 – Review at end of quarter 4	Mar 12

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY

Responsible Executive: Director of Finance

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	RISK DESCRIPTION (Obstacle to achievement of Strategic Aim)	KEY CONTROLS Any **specific measures** currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C X L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target	
6.4 (26)	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients.	• Quality assurance of plans by CSC management teams. • All Turnaround plans have supporting risk analysis completed highlighting how risks to services will be managed • Review of savings plans at both monthly performance reviews and Turnaround Committee	• Risk assessment performed by CSCs and Corporate workstreams as part of savings plan submission	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• There is a need to ensure that the risk analysis focuses on the risk to service quality as well as the risk of non-delivery.		GC: clear guidance given to CSCs and Corporate workstreams that they need to report both risks through this mechanism	Mar 12 - Review at end of quarter 4	Mar 12

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY Responsible Executive: Director of Finance												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress	
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target		
6.5 (26)	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status (links to 6.2 and 6.3)	• Turnaround workstreams/CSC initiatives with executive sponsorship • Whole System Sustainability • Planned Care Board • Unscheduled Care Board • Estates Rationalisation Board - Gap in savings plan closed by estates rationalisation	• Monthly CSC performance management & escalation, corporate workstream, finance, workforce and savings reports to TRC • Quarterly risk report to TRC • Minutes of TRC, Whole System Programme Board, SPB reporting Boards • Scrutiny by Non-Executive Director as member of TRC	16 (4x4) DB FC	8 (4x2)	8 (4x2)	• Projected year end savings with additional income adjustment leaves £300k shortfall	• £5.5m demand management savings reduced due to additional activity delivery, • Ability to deliver activity reductions impacted by numerous parties / interface issues and limited enforceable accountability • Turnaround Committee now dissolved, transferring responsibility to other major committees e.g SMT, Finance and Transformation Committees	GA: monitor activity plan/actual month by month and track updates to CSC plans for removal of costs associated with removed activity. Production of automated report to enable weekly provision by activity type (BIU/ICT/FIN) GC: further scheme may assist to ensure Trust is at break even or surplus at year end.	Ongoing Mar 12	Mar 12	

LEADS		COMMITTEE/GROUP ABBREVIATIONS		OTHER ABBREVIATIONS	
DB	Deborah Burrows	BI	Business Intelligence	CEO	Chief Executive Officer
JD	Julie Dawes	CQRM	Clinical Quality Review Meeting	CHOC	Combined Haematology Oncology Centre
SG	Steve Gooch	CSC	Clinical Service Centre	COO	Chief Operating Officer
PG	Penny Gordon	EMT	Executive Management Team	CoS	Chief of Service
SH	Simon Holmes	FC	Finance Committee	CQC	Care Quality Commission
FM	Fiona McNeight	G&Q	Governance & Quality Committee	CQUIN	Commissioning for Quality and Innovation
CM	Caroline Mitchell	ICMC	Infection Control Management Committee	EMSA	Eliminating Mixed Sex Accommodation
TP	Tim Powell	CQRM	Clinical Quality Review Meeting	ESR	Electronic Staff Record
RT	Robert Toole	PEWG	Patient Experience Working Group	HSDU	Hospital Sterilisation and Decontamination Unit
CW	Cherry West	PSWG	Patient Safety Working Group	HNU	Head and Neck Unit
		SMT	Senior Managers Team	IQP	Improving Quality Programme
		SPSSG	Staff & Patient Satisfaction Steering Group	LoS	Length of Stay
		SSCSG	Staff Satisfaction Campaign Steering Group	MHI	McKensie Hospital Institute
		SB	Sustainability Board	MSK	Musculoskeletal
		TC	Transformation Committee	PMO	Performance Management Office
		WSC	Workforce Strategy Committee	SHA	Strategic Health Authority
				SHIP	Southampton, Hampshire, IOW & Portsmouth
				SLAM	Service Level Agreement Manager
				SPB	Strategic Partnering Board

Guidance for the Assessment of Risk Rating

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Highly likely (5)	5	10	15	20	25

Green	Low Risk (1 – 3)
Yellow	Moderate Risk (4 – 6)
Amber	High Risk (8 – 12)
Red	Extreme Risk (15 – 25)

Levels of Severity of Patient Safety Indicators	
None	A situation where no harm occurred: either a Prevented Patient Safety Incident or a No Harm Patient Safety Incident.
Low	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm to one or more persons.
Moderate	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
Severe	Any unexpected or unintended incident which caused permanent or long term harm to one or more persons.
Death	Any unexpected or unintended incident which caused the death of one or more persons.