Cover page	
Meeting	Trust Board
Paper Title	Board Assurance Framework
Date of meeting	3 October 2019
Date paper was written	25 September 2019
Responsible Director	Director of Corporate Governance
Author	Governance Manager

Executive Summary

The Trust Board's main focus is strategic. Board members need to know the key strategic objectives and be able to identify the principal risks to achieving those objectives. Assurance goes to the heart of the work of any NHS board of directors. The provision of healthcare involves risk and being assured is a major factor in successfully controlling risk.

1. **The Board Assurance Framework (BAF).** The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives. It is an essential tool for Boards, and provides a structure and process that enables focus on those risks that might compromise its principal objectives. Changes proposed since last presented are shown in purple text.

2. **Corporate Risk Register (CRR).** This lists all operational risks with a validated residual score ≥15. The CRR is updated and priority ordered monthly at Operational Risk Group (ORG) and then reviewed by Sustainability, Quality & Safety, Performance and Workforce Committees each month together with the BAF. It is also reviewed at Senior Leadership Team and Audit & Risk Assurance Committee, and used at Capital Planning Group to inform the priorities for capital funding. The risks presented are an abridged summary with the full web-based detailed working risk register being held on the 4Risk system. This is used by risk owners to manage their risks with a full record of all controls, actions and narrative which is regularly reviewed by risk owners and reported at ORG.

The September 2019 summary below shows 111 risks entered onto the 4risk system with a residual score ≥15. 40 risks have been closed in the last twelve month period. 32 have an increased score of which 15 had a pre-existing 'Red' score. The number of new Corporate risks identified has increased year on year by 13.

Month	Increased score (last 12 months)	New risks (last 12 months)	Closed (last 12 months)	Current total
Sep-19	32	40	40	111

The ORG Chair's summary from the meeting on 23 September 2019 is also included for information.

The Trust Board is asked to:

- **RECEIVE and APPROVE** the recommendations with respect to the BAF *and*
- **NOTE** the updates within the Corporate Risk Register

Previously considered by	Standing item at Trust Board and all Tier 2 Committees

The Committee is asked to:			
☐ Approve	☑ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☑ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	All

Equality Impact Assessment	⦿ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	⦿ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	n/a

Operational Risk Group

Key summary points from the Operational Risk Group held on 23 September 2019.

1. New Risks added to the Corporate Risk Register (CRR)

- **CRR 1601 - Capacity within Renal Home Therapies Service**
  The Unscheduled Care Group has identified that insufficient capacity within Peritoneal Dialysis and Low Clearance service means care provided is limited. This has the potential to have clinical impact, for example, incidents of infection since 01/01/19 have increased with 22 episodes of Peritonitis, whilst in 2018/19 there were 18 cases for the whole year. The Care Group has sought additional funding which have been agreed with Specialised Commissioners and also verbally agreed with local CCGs, although written confirmation of is still pending.

  The risk was presented with an inherent risk score of 20 (Consequence 5, Likelihood 4) and although actions are in progress, members of the Group agreed a residual risk score of **20** (Consequence 5, Likelihood 4). The risk will be added to the Corporate Risk Register noting the agreement of a funding solution in principle.

- **CRR 1620 – NPSA Safety alert 16: Early Identification of failure to act on Radiological Imaging Reports**
  A significant number of serious untoward incidents have been highlighted where patients were permanently harmed by delays in appropriate management due to clinical teams not having received or read the report of the imaging investigation they had requested. A 'Rad Alert' function has been proposed which would reduce the risk of the report being missed. However the DCC Board has advised this cannot be introduced until October 2020

  ACTION: ORG recommends that the DCC Board is asked to reconsider the proposed timescales to resolve this issue

  The risk was presented with a inherent risk score of 20 but upon consideration, the Group recommended that the inherent score was raised to 25 and residual to **20** (Consequence 5, Likelihood 4), and prioritised at joint #6 in the list of 20-rated risks

2. Existing risks of increasing priority

- **CRR 714 and 830 - Theatre lights in RSH and PRH Theatres**
  The operating lights in Theatres at both sites are at the end of their life, are beyond repair and have begun to fail (some are 28 years old). There are further risks in laminar flow theatre where light failure would directly affect the capacity to carry out surgery that requires 'clean air'. One light has completely failed and is being replaced but six lights are also at risk of failure

  Members of the Group confirmed the residual risk score of **20** (Consequence 4, Likelihood 5) and prioritised at joint #6 in the list of 20-rated risks.

3. Existing risks of decreasing priority

- **CRR 1548 - Risk to the Services and Trust reputation - Secretary of State and Extended Review (Ockenden)**
  Members of the Group agreed the residual risk score remains at **20** (Consequence 4, Likelihood 5) but reprioritised from joint #2 to joint #17 in the list of 20-rated risks.

- **CRR 748 - Breast Imaging Capacity**
  Members of the Group agreed the residual risk score remains at **20** (Consequence 4, Likelihood 5) but reprioritised from joint #6 to joint #17 in the list of 20-rated risks.

4. Closed risks

A total of 14 risks have been closed by risk owners over the last period. Of these, the high-rated risks closed were:

- **CRR 1272 - Radiotherapy IT infrastructure**
  Closed by Louise Killey – Server replaced w/c 15/07/19

- **CRR 1564 - Inadequate number of CO_2 modules for monitoring intubated/ventilated patients in critical care**
  Closed by Stephanie Young - Equipment delivered to RSH ITU

- **CRR 1153 - Telepath server failure**
  Closed by Helen Harvey - Telepath server has been replaced and is now live. The server has a 3 year warranty, which should allow sufficient time to source a replacement LIMS system. A new risk will be raised relating to the need to replace Telepath itself.

- **CRR 1593 – Consultant grade microscope**
  Closed by Helen Harvey - Microscope has been ordered

- **CRR 1489 - Delay in VitalPAC upgrade and roll out of NEWS2**
  Closed by Sam Hooper - NEWS2 implemented and fully tested

5. Matters arising

- There is ongoing concern around the risks associated with imminent EU Exit, particularly pertaining to Workforce and Procurement. A paper will be presented to Board and SLT and consideration of a separate BAF risk or gap in control

- To reflect the maturing approach to approval and closure of high-rated risks, it is proposed that the Director 'sign-off' process is withdrawn and that all new risks escalated to ORG and all closed risks will only require approval in advance at the appropriate governance meeting (eg Care Group Board) which will be fully accountable for management of its risks, which is the system in place at present and is the system used by Capital Planning Group. All new and closed risks will also be presented to SLT so that there is full oversight of the decisions. This amended process will be formalised within the next iteration of the Trust's Risk Management Strategy (RM01).

- There has been significant discussion around the requirement for risk prioritisation and development of a suitable methodology to replace the current approach. Work is continuing to arrive at a consensus on the issue

Julia Clarke
Chair of Operational Risk Group
23 September 2019

Ref	Descriptor	Dir	Low-Medium-High
PATIENT AND FAMILY Listening to and working with our patients **Risk Appetite: Open**		=	**LOW / MEDIUM**
1186	*We need real engagement with our community to ensure that patients are at the centre of everything we do*	=	Medium
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care **Risk Appetite: Moderate**		=	**HIGH / MEDIUM**
1204	*Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe*	=	High/Medium
1134	*If we do not work successfully in partnership with the local health system to establish effective patient flow through well-staffed beds, then our current traditional service models will be insufficient to meet escalating demand*	=	High/Medium
1533	*We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients*	=	High/Medium
SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities **Risk Appetite: Open**		=	**MEDIUM**
561	*We need to have system-wide effective processes in place to ensure we achieve national performance standards for key planned activity*	=	Medium
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions **Risk appetite (transformation) : hungry** **Risk appetite (finance): moderate**		=	**HIGH / MEDIUM**
668	*We need to deliver our £312m hospital reconfiguration to ensure our patients get the best care*	=	Medium
670	*We need to deliver our control total and meet the trajectory to live within our financial means so we can meet our financial duties and invest in service development and innovation*	=	High
1492	*We need an agreed Digital Strategy to underpin service improvement*	=	High
1558	*We need to have sufficient, competent and capable Directors to deliver the Trust's agenda*	=	High/Medium
1584	*We need funds to invest in our aging estate and replace old equipment so we can provide higher quality care in a safe environment*	=	High
OUR PEOPLE Creating a great place to work **Risk Appetite: Open**		=	**HIGH**
423	*We need positive staff engagement to create a culture of continuous improvement*	=	High
859	*We need a recruitment strategy for key clinical staff to ensure the sustainability of services*	=	High

Key

↑	Declining
↓	Improving
=	No change

Risk ID	Description	Current Controls	Gaps in Controls	Current	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
					PATIENT AND FAMILY Listening to and working with our patients **Risk Appetite: Open**					
1186	*We need real engagement with our community to ensure that patients are at the centre of everything we do* Potential impacts: • Lack of trust from our community • Breach of legal involvement duties • Damage to Trust reputation	People's Academy established Young Peoples Academy launched Public involved with TCPS 1000+ Volunteers PACE (Patient And Carer Experience) Group established Oct 18 NHSI Review of Comms and Engagement Team implemented May 19 People's Academy graduates have key role in TCI and RPIWs as 'fresh eyes'	Integrated Comms and Engagement Strategy	Medium	Quarterly Community Engagement update to Board (Feb-19) Positive Cancer Patient Survey results (Oct 18) Positive Maternity Patient Survey results (2018) Volunteer Strategy 10,000+ public membership Patient Experience Group established (Sep-18) Patient-led Assessments of Clinical Environment (PLACE) improved Jan 19 - Privacy and dignity - Dementia care Ophthalmology engagement (Feb-19) Macmillan engagement (Feb-9) Community Connector sessions planned (Mar-Dec-19) Winners of MES Community Engagement (May-19) Ophthalmology engagement process (Jul-19) Chief Communications Officer appointed (Jul-19) Engagement Annual Report to Trust Board (Jul-19)	Formal Governance structure for members	Establish People's Forum (Dec-19) DCG Develop integrated Comms and Engagement Strategy (Jan-20)	Low	Trust Board	Director of Corporate Governance

1204	*Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe* Potential impacts: • Patients choosing other providers Avoidable harm to patients • difficulty recruiting staff • low staff morale • difficulty retaining staff	Being Open and Duty of Candour policy Revised Incident reporting policy Review meetings to review incidents, legals and complaints & SIRG VMI - Value Stream 5 (Patient Safety) Actions taken in response to CQC inspection Temporary inpatient closure of MLUs (Nov 18) QIP ISG chaired by interim CN 08.19 Interim Midwife Advisor in place.	No Head of Midwifery in post.	High	Maternity learning board presentation Maternity outcomes dashboard Neonatal Critical Care review 2018 & action plan FFT – monthly 98%+ recommendation Maternity & Neonatal Safety Collaborative – 2018 GIRFT (*Get It Right First Time*) 2018 Improvement in n CQC Maternity Survey (Jan-19) CQC Maternity score 2018 - about the same as others Linked with Princess Alexandra Hospital Harlow (Jan-19) Maternity Improvement Steering Group in place (Jan-19) Established Maternity Task Force Committee chaired by Trust Chair - (Feb-19) Maternity Assurance Committee (Chaired by Trust Chairman) CQC Engagement meetings - submission of section 31 review monthly and sign off by Div Triumvirate, CN & Md weekly. August 18 interim strategic midwife in place until new DoM starts.	Secretary of State review – expanded and delayed & open book review CQC Inspection and Conditions letter (Nov-18) Delays to CCG MLU Review	Complete Quality Improvement Plan (Sep-19) DON & embed CCG to undertake MLU Review MBRRACE data (for 2016) (Aug-19) consultation Autumn 19 Fresh Eyes Report by Interim Head of Midwifery. CNST Incentivisation Action Plan	Low	Maternity Taskforce Committee	Director of Nursing, Midwifery and Quality Chief Operating Officer
	MBRRACE results		MBRRACE results	M			MBRRACE results	L		
	SoS Review progress		SoS Review progress	H			SoS Review progress	L		
	Maternity CQC Patient Survey		Maternity CQC Patient Survey	L			Maternity CQC Patient Survey	L		
	Maternity Dashboard		Maternity Dashboard	M			Maternity Dashboard	L		

Risk ID	Risk / Potential Impacts	Controls	Gaps in Controls	Rating	Positive Assurances	Gaps in Assurances	Actions	Rating	Domain	Lead
1134 1369 1158 1197 1235 1426	*If we do not work successfully in partnership, our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand* Potential Impacts • Poor experience for patients – delays & moves • Additional patients on wards with additional staffing costs - Failure to achieve 92% bed occupancy • Reduced quality of care (sepsis, ED delays) • Low staff morale • Increased levels of Delays in Transfers of Care • Increased ambulance handover delays • Reputational damage • Clinical Safety Challenges • Recruitment and retention problems	SaTH Escalation policy & Hospital Full Protocol Weekly LHE COO meetings Shropshire, T & W A&E Delivery Board and Group VMI - Value Stream 1 Respiratory Ward Discharge roll-out VMI – Value Stream 8 (ED process) LHE Winter Plan (Sept 2019) Twice daily discharge hub meetings. Daily DTOC report LHE Complex Discharge Escalation process. SAFER programme Operational Capacity and Resilience Plan in place; SaTH2Home Red 2 Green	Unable to staff escalation wards with substantive staff Ward capacity at RSH and PRH 7-day working not in place throughout service Pre-noon discharge below NHS target 33% (SaTH at 15%) Lack of Microbiology consultants	High	Continued reduction in falls, below national levels (Dec-18) Reduction in super stranded and stranded patients (now in top quartile Maintained 21 - Q2 2019) STP update – Urgent Care, Frailty and Winter Planning Programme underway (Sept 19) Out of Hospital Programmes (Shropshire Care Closer to Home, T&W Neighbourhood Working) Review of Shropshire Community Services - Aug 2019 - linked to STP work programme. Meeting DTOC target of 3.5%. ECIST Review (Mar / June 19) CDU open at RSH (Mar-19) 7 Day Framework presented to Board July-19) Minors performance improved from 86.9% Mar 18 to 98.1% (Mar-19) Ward 35 - planned Nov 2019 Super-stranded performance maintained (Jul-19) ED performance is showing slow recovery (but not at rate planned) Orthopaedic capacity realigned at PRH (Jun-19) COO	CQC inspection - Inadequate Not delivering criterion-led discharge Escript not joined up CQC Inspection ED condition letter (Sep-18) Complex Discharge Audit Deloitte (Limited Assurance) (Feb 19) CQC Reg 31 Letter (Mar-19) Workforce Cttee 7 Day Working Assurance update (Jun-19) National Stroke Audit (Jun-19) Infection Control escalated Red (Feb 19) confirmed (Jun-19) Current ED performance remains below national average (Jun-19)	STP Recovery plan to deliver 4 hour target includes target of 85% patients being discharged within 48 hours. Mar 20 COO 7 Day Working Action Plan (June 19) WD Transfer SaTH 2 Home to Local Authorities Sept 19 CEO Establish A&E Oversight Group Jul-19 DCE A&E Delivery Board support to PRH capacity includes review of stroke rehab pathway.	Low	Quality & Safety	Chief Operating Officer
	ED 4hr Target		ED 4hr Target	H				ED 4hr Target	M	
	Sepsis CQUIN Target		Sepsis CQUIN Target	H				Sepsis CQUIN Target	L	
	Super-stranded performance		Super-stranded performance	L				Super-stranded performance	L	
	Risk Adjusted Mortality Index (RAMI)		RAMI	L				Patient mortality - RAMI	L	

1533	*We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients* (*Identified December 2018*)	PMO support	Lack of clinical oversight for SaTH PMO	High	- Monthly QIP update reports to TB	Full compliance and achievement in	SaTH PMO review into s29 and s31 reporting			

1533	*We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients* (*Identified December 2018*) Potential Impacts Patients do not receive safe, high quality care Remain in special measures Increased regulatory and press scrutiny Damage to reputation which impacts upon recruitment, clinical effectiveness and safety. Staff Retention survey results deteriorate. User surveys deteriorate	PMO support ISG and Improvement Governance structure in place (Jan-19). Chaired by NQN from Sep-19 QIP Plan agreed (Mar-19) Two weekly reporting for QIP established (Mar-19) Weekly reporting each week to NHSI/CQC against regulatory enforcement notices, providing progress on action plan. Signed off by CN & MD and Div Triumvirates. Monthly Safety Oversight and Assurance Group (SOAG) meeting with system partners established (Feb-19) SaTH PMO team in place May 19 KPIs (high-level) and root cause level) developed and reported against (May-19) Extra midwife sessions in place 8.09. Internal review of existing QIP / must and should dos.	Lack of clinical oversight for SaTH PMO	High	- Monthly QIP update reports to TB - Monthly updates against s29 and s31 regulatory notices to CQC & NHSI - Maternity (Feb-19) 90% complete (16/20) - Well-Led sessions with Board and SLT (Feb-19) - Engagement and Enablement Group to link to wider staff engagement agenda - Improvement Steering Groups established. - Monthly Scrutiny Oversight and Assurance Group established with system partners. - QIP Action plans finalised (Apr-19) - Trust has made progress Cycle 7: 163/397 'Must Dos' and 'Should Dos' - DOM appointed (Jul-19), commences Nov-19.	Full compliance and achievement in section 29 (ED) & 31 (Mat-19) Robust PMO to support QIP Key leadership role gaps (Director of Nursing) to oversee s29 and 231 reporting	SaTH PMO review into s29 and s31 reporting ownership and responsibilities Working with NHSI Improvement Director & Execs to strengthen QIP and PMO approach. Refresh of QIP Governance arrangements.	Low	Quality & Safety	Director of Nursing, Midwifery and Quality
	Progress against s29 action plan		Progress against s29 action plan	L			Progress against s29 action plan	L		
	Progress against s31 action plan		Progress against s31 action plan	H			Progress against s31 action plan	L		
	Progress against full action plan		Progress against full action plan	H			Progress against full action plan	L		

561	*We need to have system-wide effective processes in place to ensure we achieve national performance standards for key planned activity*	LHE Winter Plan (Sep 19) Whole health economy surge plan in place and monitored closely. NHSI monthly Performance Review Meeting (PRM) and Quarterly Reviews Clinical Quality Review Meeting with Commissioners SAFER programme /standard work value stream Frailty Project VMI – Value Stream 4 (Outpatients) Value Stream 8 – Surgical Pathway Value Stream 7 – CT Scans Reconstitution of Cancer Board (Mar-19) SaTH / CCG Planned Care WF	Workforce challenges and demand in - Urology - Breast - Anaesthetics National NHS pension challenge restricting some medical staff - WLI / additional PAs.	RTT Recovery plans for non-compliant specialties; Cancer Patient Survey (Sep-18) Reduction in super stranded patients – now in top quartile 99% patients received diagnostics within 6 weeks (Jun-19) CHKS Top 40 Hospitals for sixth consecutive year (Oct-18) Current DNA and 30 day readmission performance exceeds peer median and national median Cancelled Operations increased RTT position Vanguard Unit at PRH (from May-19) to address RTT target Lung Cancer Pathway undergoing TCPS treatment. MDT Rapid Improvement Week (May-19) £100k allocated by Cancer Alliance for Urology, Upper GI, Lung & Colorectal. Further cancer funding (Aug-19) to be aligned to priorities. 31 day cancer currently 97.1% against target 95% (Mar-19) 2 week target currently 89.7% against target 95% (Mar-19) Diagnostics 99.88% against 99% target (Jun-19)	Medium	14 day Cancer target pressures RTT remains below 92% 2/52 and 62 day cancer remains challenging - pressures in Breats and Radiology, Urology, Lung and Colorectal Anaesthetic staffing pressures.	Urology links being developed with UHNM - ongoing COO Planning 2 week recovery with NHSI July 19 COO RTT Recovery Plans COO 62 day target recovery (by Dec-19) COO Winter planning - capacity funding envelop (SaTH/CCGs).	Low	Performance	Chief Operating Officer
	Potential Impacts • Poor /unsafe patient care & experience • Financial penalties • Performance notices • Failure to receive STF allocation • Additional patients on wards									
	Diagnostic target		Diagnostic target		L		Diagnostic target	L		
	Cancer waiting times		Cancer waiting times		M		Cancer waiting times	L		
	RTT Targets		RTT Targets		M		RTT Targets	L		

LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions
Risk appetite (transformation) : hungry
Risk appetite (finance): moderate

ID	Risk	Controls	Gaps in Control	Assurances	Gaps in Assurance	Actions	Risk Rating		Lead
670	*We need to deliver our control total and meet the trajectory to live within our financial means so we can meet our financial duties and invest in service development and innovation* Potential Impacts • Inability to invest in development of services • Impacts on cash flow and borrowing requirement • Investment required to improve efficiency • Poor patient experience	Capital planning process and prioritisation Risk based approach to replacement of equipment Confirm and challenge meetings with Care Groups	Performance management of adverse variance to Plan Pay and non pay controls	Financial component of performance report (monthly TB)	S30 report on 2018/19 annual report and accounts 2019/20 financial position adverse to plan by £1.8m at month 4 CIP of £18.9m not fully identified at Month 4 Historic and on-going liquidity problem Recurrent deficit of £29m Mar-19 Additional cost pressures of £19.3m which will result in recurrent deficit of £42.7m (in year £32.1m) Potential cash shortfall risk (Q3) Agency overspend (Jul-19)	Progress against operational plan to be regularly reported to Trust Board – ongoing COO Deloitte commissionned to undertake CIP financial advisory project Pay and non pay controls to be reviewed	High	Medium	Performance Finance Director
	Cost improvement Programme		Cost improvement Programme			Cost improvement Programme	H	M	
	Shortfall in liquidity		Shortfall in liquidity			Shortfall in liquidity	H	M	
	Shortfall in I&E		Shortfall in I&E			Shortfall in I&E	H	M	
1584	*We need funds to invest in our ageing estate to replace old equipment so we can provide the highest quality of care in a safe environment.* Potential impacts • Unable to invest in Trust infrastructure • Lack of funds to invest in improving the environment and modern equipment • Poor patient experience	• Capital Planning process • Risk based approach • Prioritised backlog list May 19	Insufficient funds to modernise estates, equipment No rolling maintenance replacement programme for Estates/equipment Decontamination issues	Qualitative Design Review Copthorne Building (Mar-19) Monthly Estates Report to Trust Board (Apr-19) Investment in reducing highest rated risks approved (Apr-19) Diagnostic equipment Lease Purchase approved (Jun-19) Contract Award for CT Scanners for PRH Lease Purchase approved (Jun-19)	S30 report in 2018/19 annual accounts.	Space Utilisation Review Jun 19 DCG Appoint additional Compliance and Fire Function (Sep-19) DCG Appoint Associate Director of Estate (Jun-19) DCG Develop Fire Strategy for Copthorne Building (Jul-19) DCG Six Facet Survey Review (Jun-19) DCG Implement decontamination contingency (Sep-19) Refresh Seven Facet Survey, risk management and prioritisation Q3 Medical equipment and device backlog to be refreshed Q2 / Q3	High	Medium	Sustainability Finance Director
	Equipment Priority List		Equipment Priority list			Equipment Priority list	H	M	
	Estates High Risks		Estates High Risks			Estates High Risks	H	M	
	6 Facet Survey		6 Facet Survey			6 Facet Survey	H	M	

668	***We need to deliver our £312m hospital reconfiguration to ensure our patients get the best care*** Potential impacts: • unsustainable services • Suboptimal use of scarce workforce resource • Additional costs arising from current service reconfiguration • Inability to attract essential staff	Programme resources in place SaTH Sustainability Committee to oversee implementation Sustainable Service Programme STP wide Independent Oversight Group (IOG) established to oversee delivery of the acute (SSP) and community programmes NHS Transformation Unit supporting SSP in Programme Director role Appointment of Deputy Chief Executive (Jun-19) Appointmernt of Director of Strategy & Transformation and Associate Director of Transformation (Sep-19) THP timeline for delivery revised and agreed Project governance revised and agreed	Severe shortages of key clinical staff required to sustain clinical services	**Medium**	Post Consultation Business Case (PCBC) approved by a Joint Committee of the CCGs (Jan 19) CEO chairing SSP Group (Feb 19) SOC approved by Trust Board (Feb 19) SOC formally submitted to NHSI for approval (Feb 19) Increase in number of ED consultants appointed since announcement of £312m Visit by SoS to PRH (Mar 19) OBC in development (Mar 19) 3P event held 50 senior clinicians output to inform OBC development (Mar 19) completed SSP project team structure approved and recruitment due to complete (by end Jun 19) Obtain External Support for THP - procurement Oct-19 Programme Director commenced to oversee delivery of the OBC (Sep-19) Associate Director of Service Transformation to commence in post (Oct-19) Director of Clinical Effectiveness & Innovation appointed to start Jun-19 Programme Director reviewing RLB OBC development recommendations and plan for implementation (Jun-19) IRP meetings undertaken across the system	Challenge to decision (Apr- 19) Referral to SoS IRP response	Further recruitment to SSP project team to full capacity (Jul-19) Identification of additional resource required within departments and care groups to support development of the OBC (Jul-19) Recruit Director of Strategy & Transformation (Jun-19) CEO Board OBC workshop (Aug-19) OBC approval (Oct -19) • Reviewing options including inflation costs and scope • Review options for multi-story car parking and Energy Centre Meeting with NHSI re SOC delivery Clinical engagement in clinical model delivery Clinical Strategy development workshop (Nov/Dec-19)	Very Low	Sustainability	Deputy Chief Executive Officer
	Preferred option agreed	Preferred option agreed	VL			Preferred option agreed	VL		
	Outline Business Case approved	Outline Business Case approved	M			Outline Business Case approved	VL		
	Full Business Case approved	Full Business Case approved	H			Full Business Case approved	VL		

ID	Risk / Potential Impacts		Gaps		Assurance / Review	Gaps in Assurance	Actions	Current		Category	Owner
1492	**We need an agreed Digital Strategy to underpin service improvement** Potential impacts: • Risk of missed patient test results, resulting in missed or late treatment • Not having immediate access to all relevant patient information • Unable to drive or underpin clinical improvements • Risk of piecemeal approach to system purchases which could compromise overall interoperability and transformational agenda	Working towards definitive list of Trust systems Working towards implementation of Digital Change Control Board (DCCB) and associated underpinning documentation	No current Digitisation Strategy No Director-level lead across both IM & IT No Trust wide agreed process to control new systems or changes to existing systems OS upgrade required on c.500 devices to ensure continuity of Windows updates	High	Updates quarterly to Sustainability Committee Digital Steering Group and Digital Steering Committee established STP funding for increased storage (Mar-19) Board/SLT Session on Digitisation (Feb-19) Board session with NHSE Regional Directors (Jun-19) Board Session on Digitisation (Jun-19) with NHSE to agree priorities	PA review of infrastructure and EPR readiness (Feb-19) NHS Digital Trust System Support Model (TSSM) team review (Jun-19): - current infrastructure - PA infrastructure report - minimum requirements to ensure stable infrastructure	OBC - EPR/infrastructure (Jun-19) DCE Windows 10 upgrade (2019/20) DCG Appoint Digital Leader (Jul -19) DCE Appoint Cyber Security Function (Jul-19) DCG Consider Medical Records Strategy to prepare for EPR (Sep-19) - DCE Prioritisation & assessment of IT projects currently in flight through to early stages of working up, in context of team capability and capacity (Jul -19)	Low	Sustainability	Finance Director
	IT digitisation strategy approved		IT digitisation strategy	H			IT digitisation strategy in place	VL		
	Outline Business Case for EPR and infrastructure approved		Outline Business Case for EPR and infrastructure approved	H			Outline Business Case for EPR approved	VL		
	Full Business Case for EPR and infrastructure approved		Full Business Case for EPR and infrastructure approved	H			Full Business Case for EPR approved	VL		
1558	**We need to have sufficient, competent and capable Directors to deliver the Trust's agenda.** Potential Impacts • Suboptimal performance across quality, finance, performance and workforce • Lack of confidence in Trust • Reputational damage	QIP Plan Well-Led Improvement Steering Group	Lack of Leadership strategy and development programme with succession planning Lack of clearly defined organisational strategy High percentage of interim Directors	High	Stronger links with Execs and SLT through introduction of SLT Development sessions Well-Led Sessions with Board and SLT Well-Led Action Plan (Mar-19) Improved Governance Structure Tier 3 Committee Review implemented 'Plotting the Dots' session (May-19) Deputy CEO appointed (May-19) Interim FD appointed (May-19) Interim Nurse Director appointed (May-19) Deloitte Well-Led Review incorporated into well-led action plan SLT meetings now focused on joint solutions. Interim CEO appointed (Jun-19) Recruitmrnt underway into substantive posts	CQC Well-Led Inadequate (Nov-18)	Recruitment of Director of Strategy and Transformation (Sep-19) Recruitment of Head of Midwifery (Sep-19) Recruitment of substantive Executive team on course (Sep-Dec-19)	Low	Sustainability	Chief Executive Officer
	CQC Well-Led		CQC Well-Led	H			CQC Well-Led	L		
	Staff Survey immediate managers score		Staff Survey immediate managers score	M			Staff Survey immediate managers score	L		

423	*We need positive staff engagement to create a culture of continuous improvement*	Appraisals and Personal Development Plan	Rates of Statutory and Mandatory Training (currently 78%) (Aug-19)		Monthly Workforce Reports	Staff Survey – Poor engagement score (Mar-18)	Leadership Academy syllabus launch 2019 WD			
	Potential impacts: • Loss of key staff • Poor experience for patients Low staff morale • Poor work environment and experience for staff • Continued high reliance on temporary staff Increased concerns/ reports of harassment/bullying • High sickness absence including stress • staff working in excess of contracted hours	Staff induction linked to Trust values Stress risk assessments process for staff updated in partnership with Health and Safety standards 5 year workforce plan Staff engagement strategy Values Behaviours and Attitudes (VBA) training for job interviewers Leadership development programme	OD Strategy/Plan Overall deterioration in staff survey score	**High**	Annual and monthly VIP Awards. Improving Appraisal rate (88% + Medical Staff 97%) Sep-18 Think On Exec session (Mar-19) Master Coach Programme linked to Engagement Champions Think On session with SLT and Board (Apr/May-19) Engagement and Enablement Group to develop Engagement Champions - DCG (Mar-19) Think On Steering Group established (Apr-19) Training for 22 Think On Coaches May-19 17 Freedom to Speak Up Advocates appointed (May-19) 2 additional Freedom to Speak Up Guardian appointed. Engagement Champions lauch sessions (May-19) Over 50 Engagement Champions identified Bi-monthly Pulse survey introduced (May- 19) Doctor's Mess and accommodation refurbished (May-19)	Staff sickness 4.57% (Jul-19 – target 3.99%) Results of Junior Doctors GMC Survey (Aug-19) Current performance on training CQC Well-Led findings re. 'Should Dos' for staff engagement and feedback (Nov-19)	Staff App to be launched (Jul-19) Developing People Strategy to include OD (Sept -19) Engagement action plan to form part of the People Strategy (Sep-19) New revised Appraisal and Personal Development plan linked to Training Needs Analysis (Oct-19) Revision of Onboarding process to include new induction (Oct-19)	Very Low	Workforce	Workforce Director
	Recommendation as place to work		Recommendation as place to work - from staff survey results	H			Recommendation as place to work - target - staff survey results	VL		
	Motivation at work		Motivation at work - from staff survey results	H			Motivation at work - target - staff survey results	VL		
	Contribution to improvement		Contribution to improvement - from staff survey results	H			Contribution to improvement - target - staff survey results	VL		
	Experiencing bullying and harassment		Experiencing bullying and harassment - from staff survey results	H			Experiencing bullying and harassment - target - staff survey results	VL		

859	**We need a recruitment strategy for key clinical staff to ensure the sustainability of services** Potential Impacts: • Inability to continue with current provision of service • Poor experience for patients • Delays in care • Failure to comply with national standards and best practice tariffs • Reduced quality of care • Further difficulties in recruiting staff due to unreasonable on-call commitments **Urology** **Anaesthetics** **Breast Radiology**	**All** Recruitment Value Stream Workforce reviews including job redesign and skill mix reviews Process for managing staff shortages which may impact on patient care Development of new roles 5 year workforce plan Securing £312m capital allows public consultation to now occur and has reduced service anxiety due to uncertainty **Medical** Medical staffing streamlined consultant recruitment Clinical leaders managing workforce cover including "working down" Job planning Overseas recruitment **Nursing** Ward staffing templates Block booking agency staff	Full implementation of nurse staffing templates geared to nurse recruitment Lack of progress re plan for Multi-professional Ward Pilot Insufficient GI Service on two sites (Apr-19) Microbiology Consultants staffing (Apr-19)	High	**All** Workforce Report (monthly) NHSE Workforce Summit **Medical** Robust Middle Grade recruitment process (Oct 18) **Nursing** 60 new nurses starting (Sep 18) Overseas medical recruitment was successful and 17 Middle Grades recruited. Nursing recruitment Dublin (Feb-19) Junior Doctor Benefits realisation Review (May-19) Offers of employment made to 70 overseas nurses (Jun-19) Recruitment & Retention oversight committee established (Jul-19)	High levels of escalation resulting in high use of agency staff Fragility of some services (Jul-18) Workforce Committee – Low Assurance for Nurse Recruitment Strategy (Jan-19) ED Nurse Business Case approved (May-19)	Working with Walton Centre to develop a hub and spoke model for neurology (Jul-19) COO Working with Stoke to develop model for Urology (Jul-19) COO Looking at Microbiology alternative model for Service Delivery (Jun-19) COO	Low	Workforce	Workforce Director with Chief Operating Officer Medical Director Director of Nursing, Midwifery and Quality
1468 1586 748										
626	ED staffing (Consultants & Middle grades)		ED staffing (Consultants & Middle grades)	H			ED staffing (Consultants & Middle grades)	L		
1062	Gastroenterology (Medical staffing)		Gastroenterology (Medical staffing)	H			Gastroenterology (Medical staffing)	L		
817	ED Nurse staffing		ED Nurse staffing	H			ED Nurse staffing	L		
949	Critical care (Medical staffing)		Critical care (Medical staffing)	H			Critical care (Medical staffing)	L		