Cover page	
Meeting	Trust Board
Paper Title	Board Assurance Framework
Date of meeting	6 February 2020
Date paper was written	27 January 2020
Responsible Director	Director of Corporate Services
Author	Head of Corporate Affairs

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. All Tier 2 Committees review and update the BAF at each meeting where they are asked to consider and report:
    - Are the BAF risks up-to-date?
    - Is the direction of travel stated current and correct?
    - Are the current risk ratings correct?
    - Is there any additional or updated content that needs to be added?

1.1 **BAF 1746** *IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorationg medical conditions, THEN patients will not have the best outcomes possible.*
Note: This risk is the current iteration in draft for consideration by the Board.

2. **Highest scoring operational risks**. Operational risks scoring ≥15 are reviewed monthly at Operational Risk Group (ORG) and form the Corporate Risk Register (CRR). The highest scoring risks (≥20) are scrutinised through the monthly Performance Review meeting, led by the Director of Strategy & Transformation. Information taken from the 4risk system is validated by each Care Group/Service area's governance meeting and their senior management teams then describe their approach to risk mitigation to Executive Directors, committing to target dates whereby their operational risks are reduced or closed.
Note: ORG did not convene in January 2020 as no new operational risks had been identified.

Appended:

- **Attachment 1** is the updated BAF. All recommended amendments and additional content shown in purple text.
- **Attachment 2** gives reference information on risk appetite statements linked to the Trust's objectives.

Included in the supplementary information pack:

- **Attachment 3** shows the highest scoring risks (residual ≥20) taken from the CRR in December 2019.

The Trust Board is asked to:

- **APPROVE** the BAF, noting any new and revised content.
- **NOTE** the process and in particular the four questions posed to Tier 2 Committees for reviewing and updating the BAF.
- **NOTE** the summary and process for the ongoing management of high scoring operational risks.

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

The Board 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)	☑ 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

Attachment 1 - BAF risks

Ref	Descriptor	Dir	Low-Medium-High
	PATIENT AND FAMILY Listening to and working with our patients **Risk Appetite: Open**	=	**LOW / MEDIUM**
1186	*IF we do not have meaningful engagement and co-production with our community THEN patients will not be 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	*IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.*	=	High/Medium
1134	*IF we do not work successfully in partnership,THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.*	=	High/Medium
1533	*IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.*	=	High/Medium
1746	*IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorating medical conditions, THEN patients will not have the best outcomes possible*	NEW	High
	SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities **Risk Appetite: Open**	=	**MEDIUM**
561	*IF we do not have system-wide effective processes in place THEN we will not 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	*IF we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.*	=	Medium
670	*IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation.*	=	High
1492	*IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement.*	=	High
1558	*IF we do not have sufficient, competent and capable Directors THEN we cannot deliver the Trust's agenda.*	↓	High/Medium
1584	*IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment.*	=	High
	OUR PEOPLE Creating a great place to work **Risk Appetite: Open**	=	**HIGH**
423	*IF we do not have positive staff engagement THEN we cannot support a culture of safety and continuous improvement.*	=	High
859	*IF we do not have a recruitment strategy and retention strategy along with demand-based rostering for key clinical staff THEN we cannot ensure the sustainability of services.*	=	High

Key

↑ Declining
↓ Improving
= No change

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	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	***IFwe do not have meaningful engagement and co-production with our community THEN patients will not be at the centre of everything we do.*** **Cause:** Limited resource available to engage **Effect:** Lack of trust from our community **Potential impacts:** • Breach of legal involvement duties • Damage to Trust reputation	Medium / High	• People's Academy established • Young Peoples Academy launched • Public involved with TCPS • PACE (Patient And Carer Experience) Group established • Recommendations from NHSI Review of Comms and Engagement Team implemented (May-19) • People's Academy graduates have key role in TCI and RPIWs as 'fresh eyes' • Chief Communications Officer appointed (Jul-19)	Integrated Comms and Engagement Strategy	Low / Medium =	**1st Line** • Quarterly Community Engagement update to Board (Feb-19) • Volunteer Strategy 10,000+ public membership • Engagement Annual Report to Trust Board (Jul-19) **2nd Line** • Patient-led Assessments of Clinical Environment (PLACE) improved (Jan-19) - Privacy and dignity - Dementia care • Macmillan engagement process Community Connector sessions (Mar-Dec-19) **3rd Line** Winners of MES Community Engagement (May-19)		• Develop integrated Comms and Engagement Strategy (Apr 20) DCG • Review Working Together Forum present to Board (Feb-20)	Low	Trust Board	Director of Corporate Services

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1204	***IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.*** **Cause:** Lack of assurance that service failings have been addressed **Effect:** Avoidable harm to patients **Potential impacts:** • Patients choosing other providers • difficulty recruiting staff • low staff morale • difficulty retaining staff	High	• 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) • Director of Midwifery (DoM) and new Care Group Director now in post • Statutory training monitored - 90% compliance (Dec-19) • Clinical Feedback monthly meeting in place for learning from complaints/Datix/SIs • Daily safety huddles in place		Medium / High =	**1st Line** • Maternity outcomes dashboard **2nd Line** • Maternity & Neonatal Safety Collaborative etsablished • Linked with Princess Alexandra Hospital Harlow (Jan-19) • Established Maternity Task Force Committee chaired by Trust Chair - (Feb-19) • CQC Engagement meetings - submission of section 31 review weekly with sign off by DoM/CGD/DDoN • Fresh Eyes Report by Interim Strategic Midwife. • Working with the Local Maternity Systems to implement national strategic plans such as Better Births. **3rd Line** • GIRFT (Get It Right First Time) most recent position • Maternity CQC visit April 2019 by Ted Baker • CQC full review Nov 2019 - positive feedback received. Final report due March 2020.	• Secretary of State review – expanded and delayed & open book review • CQC Inspection and Conditions letter (Nov-18) • CQC Report pending March 2020 • Adequate assurance and governance processes within Care Group following CNST review • Gaps in bereavement services as highlighted in Maternity review interim report • Lack of assurance around culture change and willingness to be open with families and learn from incidents	• Establish W&C ISG as part of QIP (DTS Apr-20) • CNST Incentivisation Action Plan (Mar-20) •Review of Governance and assurance for CNST with DoM as accountable officer (Mar-20) • Full review of Bereavement services in collaboration with SANDS to take place (Mar-20) • CCG MLU Consultation imminent • Complete Action Plan for Independent Maternity Review emerging trends (Mar-20)	Low	Maternity Taskforce Committee	Director of Nursing, Midwifery and Quality Chief Operating Officer
	MBRRACE results	M		MBRRACE results	M			MBRRACE results	L		
	SoS Review progress	H		SoS Review progress	H			SoS Review progress	L		
	Maternity CQC Patient Survey	M		Maternity CQC Patient Survey	L			Maternity CQC Patient Survey	L		
	Maternity Dashboard	H		Maternity Dashboard	M			Maternity Dashboard	L		

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SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1134 1369 1158 1197 1235 1426 1585 105	***IF we do not work successfully in partnership,THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.*** **Cause:** Lack of a joined-up approach with Local Health Economy **Effect:** Failure to achieve performance and quality targets **Potential impacts:** • Poor experience for patients – delays & moves • Additional patients on wards with additional staffing costs • 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	High	• SaTH Escalation policy & Hospital Full Protocol • Weekly LHE COO meetings Shropshire, T & W A&E Delivery Board and Group • TCI/TCPS - Value Stream 1 Respiratory Ward Discharge roll-out - Value Stream 8 (ED process) LHE Winter Plan (Sep-19) • 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 • At times of high operational pressure, some patients can only be accommodated in contravention to Escalation Policy	Medium / High =	**1st Line** • Meeting DTOC target of 3.5%. • Ward 35 - planned (Nov-19) • ED performance is showing slow recovery (but not at rate planned) • Orthopaedic capacity realigned at PRH (Jun-19) COO • 7 Day Framework presented to Board Jul-19) • Minors performance improved from 86.9% Mar 18 to 98.1% (Mar-19) **2nd Line** • STP update – Urgent Care, Frailty and Winter Planning Programme underway • Out of Hospital Programmes (Shropshire Care Closer to Home, T&W Neighbourhood Working) (Sep-19) • Review of Shropshire Community Services (Aug-19) - linked to STP work programme **3rd Line** • Continued reduction in falls, below national levels (Dec-18) • Reduction in super stranded and stranded patients (now in top quartile Maintained 21 - Q2 2019) • ECIST Review (Mar / Jun-19) • RAMI performance	• CQC inspection - Inadequate (2018) • Not delivering criterion-led discharge • Escript not joined up • CQC Inspection ED condition letter (Sep-18) • Complex Discharge internal audit - Deloitte (Limited Assurance) (Feb 19) • CQC Reg 31 Letter (Mar-/Nov 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 (Jun-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	H	ED 4hr Target	H				ED 4hr Target	M		
	Super-stranded performance	M	Super-stranded performance	L				Super-stranded performance	L		
	Risk Adjusted Mortality Index (RAMI)	M	RAMI	L				Patient mortality - RAMI	L		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1533	***IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.*** **Cause:** Lack of sustained improvement **Effect:** Patients do not receive safe, high quality care **Potential Impacts** • 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	High	• 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 CGTriumvirates. • 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 (Sep-19) • Internal review of existing QIP / must and should dos. • Review of governance structure for CQC Quality iMprovement Plan underway with Interim DON and Director of Strategy and Transformation • Submitting section 29 and 31 weekly		Medium / High =	**1st Line** • 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) • DOM appointed (Jul-19), commences Nov-19. • Immediate action implemented to address additional CQC concerns (Dec-19) • Sign off by care group triumpheerate weekly and oversight before uploading to CQC Portal by DDON then sign of by DCN, MD and COO • Governance reviewed and approved at Execs (Dec-19) to be implemented in line with diaries January 20 **2nd Line** • Engagement and Enablement Group to link to wider staff engagement agenda • Improvement Steering Groups established. • QIP Action plans finalised (Apr-19) • Progresss against CQC 'Must Dos' and 'Should Dos' • Weekly reporting to CQC for additional s31 notice (Dec-19) **3rd Line** • Monthly Scrutiny Oversight and Assurance Group established with system partners.	• Full compliance and achievement in section 29 (ED) & 31 (Mar-19) • Robust PMO to support QIP • Key leadership role gaps (Director of Nursing) to oversee s29 and 231 reporting • Additional S31 notice (Nov-19) covering: - Patients presenting wiith possible sepsis or a deteriorating medical condition - De-escalation management and intervention holds - Management of minors through ED pathway • Limited capacity in nursing and operational care groups at ward/service level to consistently undertake required audits	• 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. • Additional actions to be added to QIP to address s31 notice (Dec-19) • Monthly CQC engagement meetings to commence after well led as advised by CQC on request of an update from Trust interim DON • CQC Improvement Plan and sections 29 and 31 currently being aligned to transformation programme • Developing a case and sourcing additional nursing resource and expertise to support at corporate and operational level to drive improvements at pace • Planning to introduce nursing quality and patient safety metric performance, outcome focused learning and assurance meetings by DON with HON from ward to board from February 20	Low	Quality & Safety	Director of Nursing, Midwifery and Quality
	Progress against s29 action plan	M		Progress against s29 action plan	L			Progress against s29 action plan	L		
	Progress against s31 action plan	H		Progress against s31 action plan	H			Progress against s31 action plan	L		
	Progress against full action plan	H		Progress against full action plan	H			Progress against full action plan	L		

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SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1746	***IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorationg medical conditions, THEN patients will not have the best outcomes possible.*** **Cause:** • National process, SOP and flow chart not consistently followed • Inconsistent corporate function for sepsis education and deteriorating patient intervention - due to staffing and no 24/7 service offer • Inconsistent application of the NEWS scoring across different clinical areas **Effect:** Poor patient outcomes **Potential Impacts** • avoidable harm caused to patients • mortality rates will increase • damage to reputation which impact on public confidence,staff recruitment and safety • CQC will escalate enforcement action and Trust will remain in special measures	High	• Sepsis nurse appointed (Jun-19) • Critical care outreach team • NEWS2 system in place across Trust with estbalished escalation process • Sepsis Six bundle and screening tools in place supported by Sepsis Nurse and Critical Care Outreach Team	• Lack of clarity around escalation process used by HCAs, RNs and Medical staff • PSAG does not prioritise NEWS2 score >3 • Lack of consistency in following/escalating in line with established process • Lack of resource to respond to escalation effectively	High	**1st Line** Daily checks and audits in line with CQC and escalation process - daily feedback graphs by wards / areas **2nd Line** • Sepsis Value Stream • Weekly Matrons check • Weekly Peer Audit and quarterly Clinical Audit **3rd Line** • Performance against Sepsis CQUIN • CQC Insight position	• Cultural response and engagement of frontline staff to implementation • Lack of single overaching plan for deteriorating patient (inc. sepsis) with clear SOPs and consistent documentation	• Form 24/7 Medical Emergeny Team -MD (Jan-20) • Introduce Clinical Champion/Improvement Manager to educate and raise concerns of DP/NEWS2/Sepsis 6 - MD (Jan-20) • Reinstate Nurse Alert course - DNMQ (Feb-20) • Update overarching policy for deteriorating patient with clear escalation processto.formalise documentation and outcome of reviews following escalation to ensure fitness-for-purpose and establish lines of accountability - MD (Feb-20) • Develop PSAG protocol to identify high risk patients • Resource and appoint medical DP champion to work together with sepsis nurse. • Coaching of clinicians by yet to be confirmed medical DP champion • Respond to new Sepsis/DP CQUIN being introduced for 20/21 - MD (Apr-20) • Audit Action Plan and respond - D-DNQ (Mar-20)	Low	Quality & Safety	Medical Director
	% patients screened for sepsis using the Trust screening tool vs target	H		% patients screened for sepsis using the Trust screening tool vs target	H			% patients screened for sepsis using the Trust screening tool vs target	L		
	% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	H		% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	H			% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	L		

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SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities Risk Appetite: Open											
561	***IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity.*** **Cause:** Lack of system-wide effective processes **Effect:** Poor /unsafe patient care & experience **Potential impacts:** • Financial penalties • Performance notices • Failure to receive STF allocation • Additional patients on wards	High	• 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 • TCI/TCPS – 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.	Medium =	**1st Line** • RTT Recovery plans for non-compliant specialties • Lung Cancer Pathway undergoing TCPS treatment **2nd Line** • Reduction in super stranded patients – now in top quartile • 99% patients received diagnostics within 6 weeks (Jun-19) • Cancelled Operations increased RTT position **3rd Line** • Current DNA and 30 day readmission performance exceeds peer median and national median • CHKS Top 40 Hospitals for sixth consecutive year (Oct-19) • Cancer Patient Survey (Sep-18) • 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)	• 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 • Anaesthetics 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
	Diagnostic target	M		Diagnostic target	L			Diagnostic target	L		
	Cancer waiting times	H		Cancer waiting times	M			Cancer waiting times	L		
	RTT Targets	H		RTT Targets	M			RTT Targets	L		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
670	***IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation.*** **Cause:** Inability to invest in development of services **Effect:** Potential lack of financial control **Potential impacts:** • Impacts on cash flow and borrowing requirement • Investment required to improve efficiency • Poor patient experience	High	• 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 Budgetary control and performance	High =	**1st Line** • Financial component of performance report (monthly TB) • Procurement CIP delivery **2nd Line** • Financial Improvement Board meets monthly • Workforce and Non-Pay Panels established **3rd Line** • External Audit (KPMG) • Internal Audit (Deloitte)	• S30 report on 2018/19 annual report and accounts • 2019/20 financial position adverse to plan by £1.8m at month 6 on an underlying basis • CIP of £18.9m not fully identified at Month 6 • Historic and on-going liquidity problem • Recurrent deficit of £29m Mar-19 Draft forecast outturn shows risk verses control total inc. PSF of c. £14m • Potential cash shortfall risk (Q3) Agency and non-pay overspend (Sep-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 • Accellerate action undertaken at CIP schemes	Medium	Performance	Finance Director
	Cost improvement Programme	H		Cost improvement Programme	H			Cost improvement Programme	M		
	Shortfall in liquidity	H		Shortfall in liquidity	H			Shortfall in liquidity	M		
	Shortfall in I&E	H		Shortfall in I&E	H			Shortfall in I&E	M		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
1584	***IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment.*** **Cause:** Lack of investment funding **Effect:** Inability to invest in Trust infrastructure **Potential impacts:** • Lack of funds to invest in improving the environment and modern equipment• Poor patient experience	High	• Capital Planning process • Risk based approach • Prioritised backlog list May 19 • Associate Director of Estates in post (Oct-19) • Annual 6 Facet Survey • Annual Review of medical devices backlog	• Insufficient funds to modernise estates, equipment • No rolling maintenance replacement programme for Estates/equipment • Decontamination issues • No site development plan	High =	**1st Line** • Qualitative Design Review Copthorne Building (Mar-19) • Monthly Estates Report to Trust Board (Apr-19) • Investment in reducing highest rated risks approved (Apr-19) • Draft Estates Strategy (Jun-19) **2nd Line** • Diagnostic equipment Lease Purchase approved (Jun-19) • Contract Award for CT Scanners for PRH Lease Purchase approved (Jun-19) • Capital allocated by NHSI to increase winter capacity (Mar-19) • Emergency capital confirmned for fire improvement works - Copthorne Building (Nov-19) **3rd Line** NONE	• Comprehensive phased medical equipment, devices and Estates prioritised and risk assessed replacement plan not in place	• Appoint additional Compliance and Fire Safety Officers (Jan-20) • Need to finalise Estates Strategy (Apr-20) • Need sire development plan (Apr-20)	Medium	Sustainability	Director of Corporate Services
	Equipment Priority List	H		Equipment Priority list	H			Equipment Priority list	M		
	Estates High Risks	H		Estates High Risks	H			Estates High Risks	M		
	Result of 6 Facet Survey	H		Result of 6 Facet Survey	H			Result of 6 Facet Survey	M		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
668	***IF we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.*** **Cause:** Delays in delivering the agreed programme **Effect:** Unsustainable services **Potential impacts:** • Suboptimal use of scarce workforce resource • Additional costs arising from current service reconfiguration • Inability to attract essential staff	High	• Programme resources in place • SaTH Sustainability Committee to oversee implementation Hospitals Transformation Programme (HTP) • STP wide Independent Oversight Group (IOG) established to oversee delivery of the acute (HTP) and community programmes • NHS Transformation Unit supporting HTP in Programme Director role • Appointment of Director of Strategy & Transformation and Associate Director of Transformation (Sep-19) • HTP timeline for delivery revised and agreed • Project governance revised and agreed • Draft SOC submitted (Nov-19)	Severe shortages of key clinical staff required to sustain clinical services	Medium =	**1st Line** • CEO chairing HTP Group (Feb-19) • SOC approved by Trust Board (Feb 19) • Increase in number of ED consultants appointed since announcement of capital funding for HTP • OBC in development (Mar-19) **2nd Line** • 3P event held 50 senior clinicians output to inform OBC development completed (Mar-19) • Programme Director commenced to oversee delivery of the OBC (Sep-19) • Associate Director of Service Transformation in post (Oct-19) • Clinical Strategy development workshop (Oct-19) **3rd Line** • Post Consultation Business Case (PCBC) approved by a Joint Committee of the CCGs (Jan-19) • IRP response received with recommendation to progress (Oct-19)	Awaiting feedback on SOC (Jan-20)	• Board OBC workshop (Aug-19) - Reviewing options including inflation costs and scope - Review options for multi-story car parking and Energy Centre	Very Low	Sustainability	Director of Transformation and Strategy
	Preferred option agreed	M		Preferred option agreed	VL			Preferred option agreed	VL		
	Outline Business Case approved	H		Outline Business Case approved	M			Outline Business Case approved	VL		
	Full Business Case approved	H		Full Business Case approved	H			Full Business Case approved	VL		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
1492	***IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement.*** **Cause:** Lack of a joined-up approach to delivery **Effect** Inability to drive, underpin or sustain clinical improvements **Potential impacts:** • Risk of missed patient test results, resulting in missed or late treatment • Not having immediate access to all relevant patient information • Compromise of overall interoperability and transformational agenda	High	• Working towards definitive list of Trust systems • Working towards implementation of Digital Change Control Board (DCCB) and associated underpinning documentation • Associate Director of Digital Transformation in post • Cyber security function recruited	• No current Digitisation Strategy • No Director-level lead across both IM & IT • OS upgrade required on c.500 devices to ensure continuity of Windows updates	High =	**1st Line** • Updates quarterly to Sustainability Committee • Digital Steering Committee and Digital • Change Control Board established • Board/SLT Session on Digitisation (Feb-19) **2nd Line** • Board session with NHSE Regional Directors (Jun-19) • Board Session on Digitisation (Jun-19) with NHSE to agree priorities • Board development session on cyber security (Oct-19) **3rd Line** NONE	• 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	• Windows 10 upgrade (2019/20) 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 (Oct -19)	Low	Sustainability	Finance Director
	IT digitisation strategy approved	H		IT digitisation strategy	H			IT digitisation strategy in place	VL		
	Outline Business Case for EPR and infrastructure approved	H		Outline Business Case for EPR and infrastructure approved	H			Outline Business Case for EPR approved	VL		
	Full Business Case for EPR and infrastructure approved	H		Full Business Case for EPR and infrastructure approved	H			Full Business Case for EPR approved	VL		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
1558	***IF we do not have sufficient, competent and capable Directors THEN we cannot deliver the Trust's agenda.*** **Cause:** Difficulty in recruiting due to Trust's current performance **Effect:** Lack of Trust Board capacity and capability results in uboptimal performance across quality, finance, performance and workforce **Potential impacts:** • Lack of confidence in Trust • Reputational damage	High	• QIP Plan and Well-Led Improvement Steering Group • Senior leadership strengthened with appointment of additional Deputy and Associate Director level roles across most portfolios • Board Development Plan formalised	• Lack of Leadership strategy and development programme with succession planning • Lack of clearly defined organisational strategy • High percentage of interim Directors	Medium / High ↓	**1st Line** • Well-Led Sessions with Board and SLT • Well-Led Action Plan (Mar-19) • Improved Governance Structure • Interim FD appointed (May-19) • Interim Nurse Director appointed (May-19) • Director of Strategy and Transformation appointed (Oct-19) • Associate Director of Midwifery appointed (Sep-19) **2nd Line** • Tier 3 Committee Review implemented 'Plotting the Dots' session (May-19) • SLT meetings now focused on joint solutions. • Interim CEO appointed (Jun-19) **3rd Line** • NHSI Governance Overview Nov-19	CQC Well-Led Inadequate (Nov-18)	• Recruitment of substantive Executive team on course (Nov-19 to Feb-20) • Develop action plan following NHSI reviw of previous governance assessment (Jan-20) • CQC Well-Led Review (Jan-20) • Susbstantive CEO appointment - to commence in post Feb-20 • Appoint into substantive Director posts by Jun-20	Low	Sustainability	Chief Executive Officer
	CQC Well-Led domain	H		CQC Well-Led domain	H			CQC Well-Led domain	L		
	Staff Survey immediate managers score	H		Staff Survey immediate managers score	M			Staff Survey immediate managers score	L		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
OUR PEOPLE Creating a great place to work Risk Appetite: Open											
423	***IF we do not have positive staff engagement THEN we cannot support a culture of safety and continuous improvement.*** **Cause:** Failure of Leaders to effectively engage with their workforce **Effect:** Low staff morale and poor workforce performance **Potential impacts:** • Loss of key staff • Poor experience for patients • 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	High	• Appraisals and Personal Development Plan • 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	• Rates of Statutory and Mandatory Training (currently 78%) (Aug-19) • OD Strategy/Plan • Overall deterioration in staff survey score	High =	**1st Line** • Monthly Workforce Reports • Annual and monthly VIP Awards • Think On Exec session (Mar-19) • Doctor's Mess and accommodation refurbished (May-19) **2nd Line** • Sustained improvement in staff appraisal rate 88% (Nov-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 x Think On Coaches (May-19) • 17 x Freedom to Speak Up Advocates appointed (May-19) • 2 x 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) **3rd Line** **NONE**	• Staff Survey – Poor engagement score (Mar-18) • 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)	• Leadership Academy syllabus launch 2019 WD • 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	H	Recommendation as place to work - from staff survey results	H				Recommendation as place to work - target - staff survey results	VL		
	Motivation at work	H	Motivation at work - from staff survey results	H				Motivation at work - target - staff survey results	VL		
	Contribution to improvement	H	Contribution to improvement - from staff survey results	H				Contribution to improvement - target - staff survey results	VL		
	Experiencing bullying and harassment	H	Experiencing bullying and harassment - from staff survey results	H				Experiencing bullying and harassment - target - staff survey results	VL		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
OUR PEOPLE Creating a great place to work Risk Appetite: Open											
859	***IF we do not have a recruitment strategy and retention strategy along with demand-based rostering for key clinical staff THEN we cannot ensure the sustainability of services.*** **Cause:** Inability to recruit and retain a high quality workforce **Effect:** Inability to continue with current provision of service **Potential impacts:** • 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	High	**All** • Recruitment Value Stream • Workforce reviews including job redesign and skill mix reviews • Process established for managing staff shortages where potential impact on patient care • Development of new roles 5 year workforce plan • Securing adequate capital has reduced service anxiety due to uncertainty • Development of a People Strategy **Medical** • Medical staffing streamlined consultant recruitment • Clinical leaders managing workforce cover including "working down" • Robust 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 =	**1st Line** • Workforce Report (monthly) • NHSE Workforce Summit **2nd Line** • Overseas medical recruitment was successful in nursing and middle grade appointments throughout 2019 • 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) **3rd Line** **NONE**	• 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	Urology	H		Urology	H			Urology	L		
1586	Anaesthetics	H		Anaesthetics	H			Anaesthetics	L		
748	Breast Radiology	H		Breast Radiology	H			Breast Radiology	L		
626	ED staffing (Consultants & Middle grades)	H		ED staffing (Consultants & Middle grades)	H			ED staffing (Consultants & Middle grades)	L		
1062	Gastroenterology (Medical staffing)	H		Gastroenterology (Medical staffing)	H			Gastroenterology (Medical staffing)	L		
817	ED Nurse staffing	H		ED Nurse staffing	H			ED Nurse staffing	L		
949	Critical care (Medical staffing)	H		Critical care (Medical staffing)	H			Critical care (Medical staffing)	L		

Risk Appetite statement by objective

Risk appetite is the level of risk the Trust will take in pursuit of its objectives

Trust Objectives	Risk Appetite Statement	Appetite (level)
1 Listening to and working with our patients and families to improve healthcare	*The Trust is keen to consider all delivery options and select those with the highest probability of productive outcomes even when there are elevated levels of associated risk*	4 Open
2 Our patients and staff will tell us they feel safe and received kind care	*The Trust will support innovation with demonstration of commensurate improvements in outcomes. Systems / technology used routinely to enable operational delivery.*	3 Moderate
3 Working with our partners to promote 'Healthy Choices' for all our communities	*The Trust is prepared to take decisions that are likely to bring scrutiny but where the potential benefits outweigh the risks. Value and health benefits will be considered, not just cost and resources allocated to capitalise on opportunities.*	4 Open
4 a) Innovative and Inspiration Leadership to deliver our ambitions (transformation)	*The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk*	5 Hungry
4 b) Innovative and Inspiration Leadership to deliver our ambitions (finance)	*The Trust is prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.*	3 Moderate
5 Creating a great place to work	*The Trust will encourage new thinking and ideas that could lead to enhanced staff engagement*	4 Open

Risk Appetite definitions

1	**Averse:**	Avoidance of risk and uncertainty is a key organisation objective.
2	**Minimal:**	Preference for ultra-safe options that are low risk and only have a potential for limited reward.
3	**Moderate:**	Preference for safe options that have a low degree of risk and may only have limited potential for reward.
4	**Open:**	Willing to consider all potential options and choose the one most likely to result in successful delivery, while also providing an acceptable level of reward and value for money.
5	**Hungry:**	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.