The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
6 May 2021

Agenda item	106/21			
Report	Board Assurance Framework (Q4)			
Executive Lead	Director of Governance and Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people	√	Effective	
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		All BAF risks	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Audit and Risk Assurance Committee 12 April 2021			
Dependent upon (if applicable)**:**				
Executive summary:	The Audit and Risk Assurance Committee have considered the Q4 BAF and recommend approval by the Board, also recognising that this will be the final presentation of the 2020/21 BAF to Board. A Board Seminar was held on 15 April 2021, and considered proposed amendments to the BAF risk descriptors for 2021/22, based upon the Trust's strategic pillars and goals. Details are provided in section 2 of this report. The Board is asked to: ○ approve the 2020/2021 Q4 BAF, recognising that this will be the outturn of the 2020/21 BAF. ○ approve the 2021/22 risk descriptors Risk 1 – Risk 9 ○ consider, and if appropriate, to approve the draft risk descriptors Risk 10 and Risk 11.			
	Appendix A - summary from the 2020/21 BAF Appendix B – full BAF for Q4, and 2020/21 year end			

1.0 Board Assurance Framework, 2020/21

1.1 As board members / members of the Committee will be aware, the BAF was drawn up by Kevin Street, former Risk Management Consultant, during the second quarter of 2020 and used a generic format and content.

1.2 The various BAF risks have been presented to the board assurance committees on a monthly basis, with updates fed back through the executive lead, in order that details can be updated.

1.3 The 'full' version of the BAF for Q4 was considered by the Audit and Risk Assurance Committee on 12 April 2021 and highlighted a number of outstanding 'actions' that showed that completion was due by 31 March 2021. These actions have been reviewed by the executive directors and considered whether the action:

1. Has been completed;
2. Remains outstanding and to be taken forward to 2021/22 BAF;
3. Remains outstanding, but will now instead be tracked through an alternate route. Not to be taken forward on the BAF;
4. Remains outstanding, but no longer relevant, and should not be taken forward to 2021/22 BAF.

1.4 The outcome of that work is shown on the current 'full' version, and will support the 2021/2022 BAF formulation.

1.5 As the document is presented at the end of Q4, this is also the final BAF for 2020/21.

1.6 A summary of the end of year risk scores from the BAF is provided at appendix A, with a copy of the 'full' BAF appearing at appendix B.

2.0 Board Assurance Framework, 2021/22

2.1 When referring to the BAF, we must remember that the Board Assurance Framework consists of more than the document which has been provided with this report, i.e. it is more than a risk register. The Board Assurance Framework includes all the processes and systems that the Board has in place (such as committees, corporate documentation, etc.) to ensure that Board is able to carry out its required duties of formulating strategy, ensuring accountability, and shaping culture[1].

2.2 However, for this report we are looking at the BAF 'risk document' that is attached herewith.

2.3 This risk document highlights the strategic risks that may affect delivery of the organisation's objectives. Operational risks appear on the operational risk register, not on the BAF[2]. As the risks are strategic, it is unlikely that they will change on a monthly basis. For that reason, the BAF 'risk document' risks which are aligned to our board committees, will be presented to the board committees on a quarterly basis. Thereafter, the 'full' BAF 'risk document' risks will be presented to the Audit and Risk Assurance Committee, before being brought to the Board on a quarterly basis. The Board will be asked to approve any proposed amendments to the BAF risks, the quarterly scoring, etc.

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[1] NHS Leadership Academy, The Healthy NHS Board 2013 Principles for Good Governance.

[2] However, it is possible, although rare, that an operational risk could become a strategic risk.

2.4 At a board seminar held on 15 April 2021, the 2021/22 BAF was discussed and a number of proposals made with regard to refreshing the risk descriptors so that they more reflected the organisation's strategic risk. The descriptors were drawn up respecting up to date best practice. In addition, content of those Trusts deemed outstanding by the CQC, were also reviewed. All directors were provided with the opportunity to provide feedback during and after the seminar.

2.5 With consideration of the existing, generic risk descriptors, a list of new risk descriptors were considered:

Risk 1: Poor standards of safety and quality of patient care across the Trust results in incidents of avoidable harm and / or poor clinical outcomes;

Risk 2: The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience;

Risk 3: The Trust is unable to attract, develop and / or retain its workforce to delivery outstanding services;

Risk 4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale and well-being;

Risk 5: The Trust does not operate within its available resources;

Risk 6: Some parts of the Trust's estates infrastructure, buildings and environment may not be fit for purpose;

Risk 7: The inability to develop, maintain or replace digital systems, impacts upon security, functionality and deliver of patient care;

Risk 8: The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards; and

Risk 9: The Trust is unable to restore and recover services post-Covid to meet the needs of the community / service-users.

2.6 The statements all appear to be negative. However, it is important to remember that they describe the risk, not the actual state of affairs.

2.7 The issue of maternity care / Ockenden was also discussed in some detail, and particularly whether this should have its own strategic risk. Discussions focussed on clarity as to what the actual strategic risk was. (That is not to say that risk is not acknowledged.)

- Is the risk relating to the occurrence of avoidable harm and poor clinical outcomes? Or is it relating to poor standards of safety and quality of care? (See risk 1 above).

- Is the risk relating to a perceived lack of an embedded safety culture in 2021? Or is it relating to a lack of evidence of continuous improvement and patient experience? (See risk 2 above.)

- Is the risk relating to the ability to recruit and develop workforce capacity to deliver the service? Or, is it due to the potential effect that lack of capability and capacity has on the workforce? (See risk 3 and 4 above.)
- Or, is the risk relating to the ability to consistently meet statutory and / or healthcare standards? (See risk 8 above).

2.8 The strategic risks highlighted in section 2.7 could all be applied to the findings of the first Ockenden Report, which have also been highlighted by other stakeholders. But they could also be applicable to other areas of the Trust. For that reason, it was considered by the majority, that the BAF would not include a separate strategic risk associated only with maternity care / Ockenden.

2.9 However, one area that is not covered, and which was highlighted during discussions, and which has been raised by various stakeholders, is the culture within the Trust.

2.10 With this in mind, and recognising that an extensive cultural programme is already in place, it is proposed that an additional strategic risk be added, akin to:

Risk 10: If staff do not observe Trust values and cultural expectations, poor quality care and services are likely to result.

2.11 Discussion also took into account the change of status of the Shropshire, Telford and Wrekin Sustainability Transformation Partnership (STP), to becoming an Integrated Care System (ICS) as from 1 April 2021. The Board recognised the strategic risk, should the Trust not be able to work collaboratively to enable the ICS to provide sustainable, transformational services which align with national policy. It was agreed that a further organisational strategic risk should be added, akin to:

Risk 11: The organisation will not benefit from ICS service transformation without the appropriate in-house skills, resources, and capacity to enable the required levels of engagement to support change at pace.

3.0 Conclusion

3.1 The Board is asked to follow the recommendation of the Audit and Risk Assurance Committee and approve the 2020/2021 Q4 BAF, recognising that this will be the outturn of the 2020/21 BAF.

3.2 In order to proceed with the 2021/22 arrangements, the Board is asked to approve the 2021/22 risk descriptors Risk 1 – Risk 9 as previously discussed.

3.3. The Board is asked to consider, and if appropriate, to approve the draft risk descriptors Risk 10 and Risk 11.

Anna Milanec
Director of Governance and Communications
April 2021

Appendix A

Link to SaTH Strategic Goals	BAF RISK ID	Risk title	Risk Owner	Oversight Committee	Y/e residual risk score
We deliver safe and excellent care, first time, every time	**B1**	There is a risk of prolonged and/or substantial failure to deliver standards of nursing care.	DoN	QSAC	4x3 = 12
Our services are efficient, effective, sustainable and deliver value for money	**B2**	There is a risk of not achieving constitutional and national performance targets.	COO	QSAC	4x4 = 16
We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised	**B3**	Financial sustainability: Deliver the Trust control total for 2021/22 of £[]m (to be agreed) while improving the underlying position.	DoF	FPAC	5x4 = 20
Our staff are highly skilled, motivated, engaged and 'live our values' SaTH is recognised as a great place to work	**B4**	There is a risk of risk of not recruiting or retaining staff.	DoW	QSAC	3x4 = 12
We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure	**B5**	There is a risk that the current and future estates, infrastructure and equipment does not comply with national specifications, meet service needs and/or service user needs.	DCS	FPAC	5x3 = 15
We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure	**B6**	There is a risk of not providing robust digital infrastructures and defences against cyber security. Also the ability of the Trust to provide and use reliable data (business intelligence), making best use of technology is compromised.	DoF	FPAC	4x3 = 12
We have outstanding relationships with our partners and collectively strive to improve the quality and integration of health and care services	**B7**	There is a risk of not delivering expected and planned transformational service redesign.	DS&T	FPAC	4x3=12
We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised	**B8**	There is a risk of not adequately meeting CQC Health & Social Care regulations.	DoN	QSAC	4x4 = 16
Our services are efficient, effective, sustainable and deliver value for money	**B9**	There is a risk that the impact of COVID-19 continues to affect the Trust's quality outcomes and targets	MD	QSAC	5x3 = 15
Our services are efficient, effective, sustainable and deliver value for money	**B10**	There is a risk around the uncertainty of Brexit.	COO		4x2 = 8
We deliver safe and excellent care, first time, every time	**B11**	There is a risk of prolonged and/or substantial failure to deliver standards of maternity care.	DoN	QSAC	3x5 = 15

Created Date	Risk Ref	Risk Title/Descriptor	Strategic Objective	Cause & Effect	Assurance Committee	Inherent Risk Priority	Residual Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gap(s) in Control / Assurance	Overall Assurance Assurance Level	Action Required	Progress Notes	Target Risk Priority
29/09/2020	**BAF 1**	There is a risk of substantial failure to deliver standards of nursing care. Executive Lead: Hayley Flavell Operational Lead: Kara Blackwell Last Updated: 22 Apr 2021	We deliver safe and excellent care, first time, every time	Hazard(s) / Cause(s): Inconsistencies in care relating to: •Safeguarding Patients •Falls Prevention and Management •Infection Prevention and Control •Tissue Viability •Nutrition and Hydration •Patient Experience •End of Life Care •Vulnerable Patients Effect(s) & Impact(s): The Trust may not meet these standards due to: •Clarity of standards and frameworks especially where practice may be different across sites •Incomplete training and competencies •Inconsistencies in governance arrangements •Inability to recruit and retain the right numbers and skill mix of nursing staff •Individual substandard practice of registered health professionals	Quality and Safety	I = 4 L = 4 16	I = 4 L = 3 12	Corporate Induction and ongoing mandatory training for all staff outlines required standards of practice and care, including temporary staffing. Control Owner: Rhia Boyode	Monthly Matrons Nursing Quality Assurance Audits Ward Dashboard linked to the Exemplar Programme	Divisional PRMs and Trust level IPR at QSAC and Board	Presented at IPR at Trust Board Presented at QSAC commencing Apr-21	Visibility of ward level detail	Limited Assurance Date: 17 Dec 2020 Assurance By: Tony Holt	Develop and Operational Plan to deliver the 3 year Quality Strategy Person Responsible: Hayley Flavell To be implemented by: 31 Mar 2021	**09 Apr 2021** Quality Strategy presented at QSAC and Board Getting Yr 2 Plan on a Page completed	I = 4 L = 2 8
								Internal policies and procedures detail the required standards and practice for nursing care in each specialist area. Control Owner: Hayley Flavell	The NIQAM in place chaired monthly by DoN monitors compliance and performance with standards of care.	Weekly and monthly audits as part of Section 31 Conditions signed off by DoN	Clinical audit programme & monitoring arrangements	Group to agree approve and oversee policies, procedure and SOPs	Adequate Assurance Date: 21 Jan 2021 Assurance By: Tony Holt	Quality Operational Committee (QOC) - standardisation of reports Person Responsible: Hayley Flavell To be implemented by: 30 Jun 2021	
								Quality Nursing metrics that routinely monitor standards of care. Control Owner: Kara Blackwell	Monthly DoN Nursing Quality Assurance Meeting with HoN, Matron and Ward manager to review compliance with Nursing and Quality KPIs	QSAC, chaired by the Non-executive Director, receives monthly assurance reports from Assurance Committees responsible for the following areas: • Safeguarding Patients via Safeguarding Committee Highlight Report • Falls Prevention and Management (reports Quarterly) • Infection Prevention and Control Assurance Committee • Tissue Viability via the IPR and Quality Report • Nutrition and Hydration • Patient Experience /Complaints reports Quarterly • End of Life Care Steering Group monthly Highlight Report • Section 31 and 29A Report includes update on patients who have required restrictive intervention, MCA/DoLs and Nursing Quality Audits	• Integrated Performance Review to Board and monthly IPC report • Ward Dashboard which triangulate all ward quality metrics, training and workforce data		Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt	Review all ward establishment Standard Operating Procedures and review all ward templates Person Responsible: Clair Hobbs To be implemented by: 30 Jun 2021	**22 Apr 2021** CH: Monitored at startegic Nursing, Midwifery & AHP Workforce Group. AAA report is a standing item at QSAC	
														Establishment of Vulnerable patient Group Person Responsible: Kara Blackwell To be implemented by: 30 Sep 2021		
														Review of interim posts to ascertain whether BC is required Person Responsible: Kara Blackwell To be implemented by: 30 Sep 2021		
														Standardisation of information from Ward to Board Person Responsible: Hayley Flavell To be implemented by: 30 Sep 2021	**09 Apr 2021** HF: Review of QOC reports and clinical dashboard completed	
														Development of Specialty area dashboards (eg ED, ITU, Paeds) Person Responsible: Kara Blackwell To be implemented by: 30 Sep 2021		

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	BAF 1							Reporting and Management of Incidents via Datix provides a route for all staff to raise concerns and report issues. Control Owner: Kath Preece	Nursing Incident Quality Assurance Meeting (NIQAM)	• Incidents reviewed via PRM and QOC • Nursing Incident Quality Assurance and Management Group (NIQAM) review all incidents that may result in severe (reportable) harm, quality assuring investigation reports, identifying and sharing lessons, escalation if required, ensuring the contractual requirements in relation to reports to the Commissioners are met. • Pressure Ulcer RCA meeting for all category 2 and above hospital acquired pressure ulcers (excludes those that meet threshold for SI which go to NIQAM) • Falls Steering Group monthly	CQRM and Board oversight	Variation in reports from Divisions	Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt	Establish Group to oversee clinical guidelines and SOPs Person Responsible: Anna Milanec To be implemented by: 30 Sep 2021		

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	BAF 1							Specialist Corporate Nursing Teams that support ongoing monitoring, scrutiny and improvement of standards of care. Control Owner: Kara Blackwell	Monthly DoN Nursing Quality Assurance Meeting with HoN, Matron and Ward manager to review compliance with Nursing and Quality KPIs	• Exemplar Ward Review Programme • CQC meeting with ED around all Section 31 notices Section 29A warning notices discussed at monthly EOCL Steering Group and Safeguarding Operational Groups. • CQC Safeguarding Action Plan Update presented Quarterly at Safeguarding Committee. • Section 31 report monthly to QOC attended by Divisions outlines performance against all conditions	Section 31 and 29A Weekly/monthly reporting to CQC, CCG, NHSI/E Monthly reporting to SOAG and CIC	Gaps in relation to ongoing resourcing of posts currently not substantive. Vulnerable patient Group	Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt		
								Ward level quality dashboards that provide real time data in relation to standards of care. Control Owner: Kara Blackwell	Weekly Rapid Review meeting reviews all incidents (moderate or above) and complaints and a weekly activity report presented at RALIG chaired by Medical Director/DoN	• CQRM monthly meeting CQC/SOAG/CIC • Nursing Dashboards in place for adult wards which triangulate all quality, training and workforce metrics, monthly assurance meetings chaired by DON to challenge performance and provide support Exemplar Programme	QOC, QSAC	Dashboards for speciality areas incluing ED, ITU and Paeds being developed	Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt		
								Ward Safer Staffing Template Control Owner: Clair Hobbs	Daily Review by clinical teams Daily meeting chaired by D-Don	Strategic Non-Medical Workforce Meeting chaired by DoN Safe staffing report submitted annually to Public Board meeting and QSAC	Safer Staffing Reports.	Divisional dashboard in development Q2 21/22 Inability to staff escalation wards with substantive staff	Limited Assurance Date: 05 Mar 2021 Assurance By: Tony Holt		

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30/09/2020	BAF 2	There is a risk of not achieving constitutional and national performance targets. Executive Lead: Nigel Lee Operational Lead: Sara Biffen Last Updated: 15 Apr 2021	We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised	Hazard(s) / Cause(s): A failure to meet constitutional and National performance targets , eg EUC waiting times, Referral to Treatment (RTT) times for elective and cancer diagnostic waiting times. Effect(s) & Impact(s): May lead to sub-optimal care, financial penalties, regulatory action and damage to reputation and negative impact on public confidence.	Finance & Performance	I = 4 L = 5 20	I = 4 L = 4 16	Cancer performance management Control Owner: Nigel Lee	• MDT-level management and monitoring • Monthly reporting to Care Group Committees	• Weekly Trust Cancer performance meetings • Cancer Assurance Committee • Standing monthly reports to QSAC and FPAC	• West Mids Cancer Alliance Reviews • NHSI reviews	• Workforce challenges in Urology, H&N and Radiology • Covid impact on capacity and staff	Substantial Assurance Date: 15 Apr 2021 Assurance By: Tony Holt	Agree and implement workforce plans for key specialties (RTT and Cancer) Person Responsible: Rhia Boyode To be implemented by: 30 Sep 2021	**15 Apr 2021** NL: Yr 2 of international recruitment programme to be signed off at system level for: • Radiology staffing • Theatre staffing (raised with Suzy Cook) • Monitored at OPG	I = 4 L = 2 8
								Capacity and Demand planning as part of 21/22 plan Control Owner: Nigel Lee	• Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand	• Trust operational plan including revisions for Covid • Standing monthly reports to QSAC and FPAC	• STW system capacity and demand planning • NHSI UEC reviews	Capacity shortfall to deliver UEC and elective demand	Limited Assurance Date: 15 Apr 2021 Assurance By: Tony Holt	Delivery of 1 x new CT scanner and 1 x MRI scanner Person Responsible: Sheila Fryer To be implemented by: 30 Sep 2021	**15 Apr 2021** NL: new equipment and capital works on track. Seek to resolve workforce issues through wider international recruitment project.	
								Recovery programme for RTT/Diagnostics Control Owner: Nigel Lee	Departmental and Care group monitoring of: • RTT • Imaging • Endoscopy • Weekely Exec briefing	• Weekly Restoration & Recovery Group • Standing report to FPAC	• STW Acute & Specialist Care Group oversight • STW Diagnostic Group oversight • NHSI Endoscopy Task Group	• Covid impact on activity and workforce • Workforce (Theatres/Radiology) • Clinical prioritisation and potential harm	Limited Assurance Date: 15 Apr 2021 Assurance By: Tony Holt			
								UEC Programme Control Owner: Nigel Lee	• Performance and quality management by Emergency Centre/Care Group • Site safety process • SaTH Escalation inc. Full Hospital protocol	• Performance and recovery actions reported to QSAC • SDEC project group reporting to FPAC • UEC internal flow project	• System UEC Group and Board • NHSI reviews of SaTH/STW STP	• Covid demand and impact • Workforce constraints across ED/acute/medicine • Variance in demand • System capacity for admission avoidance	Limited Assurance Date: 15 Apr 2021 Assurance By: Tony Holt	Secure additional capacity for 20/21 including options for: • permanent capacity • insource • outsource • use of IS Person Responsible: Nigel Lee To be implemented by: 31 Mar 2021	**15 Apr 2021** Detail BCs for permanent capacity resubmitted to ICS/STP Board for support.	

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	BAF 2													Complete expansion of Endoscopy capacity (Althea) Person Responsible: Neil Rogers To be implemented by: 31 Mar 2021	NL: Contract signed and implemented during Q4 20/21	
														Patient flow improvement Person Responsible: Sara Biffen To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: Patient flow Yr1 objectives met	
														Deliver ED Quality Improvement Plan Person Responsible: Carol McInnes To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: Evidence and rationale for closure against 11xCQC conditions relating to ED for consideration, expected to be concluded end of May-21	
														Clinical prioritisation of waiting lists Person Responsible: Mark Cheetham To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: Continues as a live action but formally complete for Q3/4.	
														2020/21 recovery plan Person Responsible: Sara Biffen To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: Plan drafted subject to capacity and funding. Ongoing monitoring via Operational Performance Group and Recovery Task & Finish Group	
														SDEC development Person Responsible: Carol McInnes To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: Estates development complete. Workforce development ongoing. 'How we're doing' monitored at ED Improvement Committee	
														2021/22 update on capacity and demand including backlogs Person Responsible: Sara Biffen To be implemented by: 31 Mar 2021	**15 Apr 2021** NL: 95% complete. Ongoing monitoring via Operational Performance Group	

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30/09/2020	BAF 3	Financial sustainability: Deliver the Trust control total for 2021/22 of £[]m (to be agreed) while improving the underlying position. Executive Lead: James Drury Operational Lead: Paul Corlass Last Updated: 20 Apr 2021	Our services are efficient, effective, sustainable and deliver value for money	Hazard(s) / Cause(s): A failure to maintain financial sustainability due to non-planned cost pressures Effect(s) & Impact(s): Potential external action being taken; damage to the Trust's reputation and the Trust's continuing abilities to function; and the imposition of regulatory controls leading to the loss of local control.	Finance & Performance	I = 5 L = 5 25	I = 5 L = 4 20	●Centralisation of controls over discretionary spending ●Performance management of Division off track ●Tight management of capital and working capital ●Agreement with NHSE/I of realistic and achievable financal plan and trajectory ●Development and implementation of training programmes on financial sustainability ●Increase capacity to deliver major change projects ●Delivering benefits from UEC investment ●Medium to Long Term Plan Recovery Plan ●Recovery and restoration of Elective programme Control Owner: James Drury	●Budget reviews at service level ●Divisional Performance Management meetings ●IIC, SLC-T, SLC-O approval process ●F&P Assurance Committee Finance report and related papers ●Integrated Performance Report including Finance Exception Report ●21/22 budget setting and operational plan process ●Pay and non -pay review groups	●Workforce recruitment and retention plan ●Benefits realisation from quality and safety invetments business cases ●COVID-19 de-escalation plan	System Financial Recovery Plan	●Re-establish Pay/Non-Pay review groups (Q4 20/21) ●CIP identification (Q1 21/22) ●Approval of overseas nurse recruitment business case ●System Financial Recovery Plan/Transformation ●Effective performance management ●21/22 Control Total agreement and 3-5 year trajectory ●Financial training programme ●Capacity assessmePlan ●COVID-19 De-escalation Plan	Limited Assurance Date: 20 Apr 2021 Assurance By: Tony Holt	Elective Recovery Plan Person Responsible: Nigel Lee To be implemented by: 28 May 2021	**20 Apr 2021** HT: Draft system operating plan to be finalised by 6 May	I = 5 L = 3 15
														Capacity Assessment for efficiency/major change projects Person Responsible: Chris Preston To be implemented by: 30 Jun 2021	**20 Apr 2021** HT: Risk based approach to focus on biggest/best returns	
														CIP Person Responsible: James Drury To be implemented by: 31 Jul 2021	**20 Apr 2021** HT: Incorporated into Efficiency Programme led by COO and DoF supported by respective deputies. Cross cutting themes to be identified and overall plan agreed by 31 July-21	
														System Financial Recovery Plan Person Responsible: James Drury To be implemented by: 30 Sep 2021	**20 Apr 2021** HT: Covid financial regime rolls over to end of Q2	
														Control Total Agreement Person Responsible: James Drury To be implemented by: 31 Mar 2021	**20 Apr 2021** Implemented	
														COVID-19 De-escalation Plan Person Responsible: James Drury To be implemented by: 31 Mar 2021	**20 Apr 2021** Implemented	
														Establish Pay/Non-Pay Review Groups Person Responsible: James Drury To be implemented by: 31 Mar 2021	**20 Apr 2021** HT: Draft budgets by Jun-21	

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30/09/2020	BAF 4	There is a risk of risk of not recruiting or retaining staff. Executive Lead: Rhia Boyode Operational Lead: To be allocated Last updated: 22 Apr 2021	Our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care	Hazard(s) / Cause(s): An inability to recruit and retain an appropriate workforce to meet the needs of the current and future patient base Effect(s) & Impact(s): May lead to the Trust breaching guidance, regulatory action being taken against the Trust; poorer patient outcomes and increased harm; and adverse publicity and/or reputational damage. Furthermore this may lead to the financial unsustainability of some services.	Quality and Safety	I = 3 L = 5 15	I = 3 L = 4 12	People Strategy in place to inform organisational approach to recruitment, retention and Education & Development of our staff. Control Owner: Rhia Boyode	• Medical and Nursing task force • Workforce Planning Group • Exec Talent Management Group • Activity, Workforce and Financial plan processes (consultant job planning; workforce modelling; winter capacity plans) • Vacancy management and recruitment systems and processes • TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation • Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure • Temporary staffing approval and recruitment processes with defined authorisation levels	• TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation • Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure • Temporary staffing approval and recruitment processes with defined authorisation levels • Director of People attendance at People and Culture Board • Workforce planning for system workstream • Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice • Pensions restructuring payment introduced • Pensions tax education and information exchange sessions • Daily COVID-19 workforce group and sub-groups to address related concerns	• Local/Regional/National Education partnerships	• High levels of escalation resulting in high use of agency staff • Fragility of some services (ongoing) • Trust reputation issues associated with Special Measures	Limited Assurance Date: 20 Apr 2021 Assurance By: Tony Holt	New revised Appraisal and Personal Development plan linked to Training Needs Analysis Person Responsible: Rhia Boyode To be implemented by: 28 May 2021	**22 Apr 2021** RB: Programme revised to include Health & Wellbeing elements into appraisals. Delayed due to Covid, to be relaunched May-21	I = 3 L = 2 6
														Recruitment & retention strategy subsumed into People Strategy Person Responsible: To be allocated To be implemented by: 30 Dec 2020	**22 Apr 2021** RB: Signed off by Board Nov-20 Monitored at QSAC and Board	
														Revision of Onboarding process to include new induction Person Responsible: To be allocated To be implemented by: 31 Dec 2020	**22 Apr 2021** RB: Launch of onboarding team completed to improve induction and exit process	

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30/09/2020	BAF 5	There is a risk that the current and future estates, infrastructure and equipment does not comply with national specifications, meet service needs and/or service user needs. Executive Lead: Julia Clarke Operational Lead: Will Nabih Last Updated: 13 Apr 2021	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure	Hazard(s) / Cause(s): The ageing buildings, physical environment, associated infrastructure and inadequate backlog resources present a risk of services failing and impacting on the delivery of patient services. Effect(s) & Impact(s): There is a risk of the Trust breaching its conditions; regulatory action being taken against the Trust; poorer patient outcomes and/or patient harm; and adverse publicity and reputational damage.	Finance & Performance	I = 5 L = 4 20	I = 5 L = 3 15	Board-approved fully funded Capital Programme including backlog maintenance plan and medical equipment budget in place. Control Owner: Will Nabih	Capital plan developed and overseen by CPG	Approval through SLC and Trust Board	Internal Audit oversight and reporting through ARAC	Capital available against ageing estate	Adequate Assurance Date: 12 Apr 2021 Assurance By: Tony Holt	Development of Capital Plan for 21/22 - to be presented to May Trust Board Person Responsible: James Drury To be implemented by: 28 May 2021		I = 5 L = 2 10
								Estates Plan 2015-2025 in place (with interim plan for 2021) Control Owner: Will Nabih	• Monthly Estates report to SLC-O • Independent Authorising Engineers (APs) recruited	• Additional capital allocation for backlog maintenance secured • Quarterly report on all aspects to F&P from April 21	• Annual Oakleaf six facet survey • Sign off of Ward 36 (PRH) and SDEC (RSH) • Weekly report to NHSI on major schemes	• Lack of clinical service vision • Clear alignment with HTP and potential to expedite schemes	Adequate Assurance Date: 12 Apr 2021 Assurance By: Tony Holt	Development of Estates Plan for 21/22 Person Responsible: Julia Clarke To be implemented by: 31 Jul 2021	**12 Apr 2021** JC- to be presented to July Trust Board following finalisation of Capital Plan and Service Delivery priorities	
								Programme of planned preventative maintenance (PPM) in place Control Owner: Will Nabih	MICAD system utilised for planning and monitoring	Progress reported monthly to Director of Corporate Services	Annual Six Facet Survey	Adequate number of Competent Engineers (CPs) to undertake PPM	Adequate Assurance Date: 12 Apr 2021 Assurance By: Tony Holt	Agreement to appoint into establishment based on concomitant reduction in external contractors costs and CIP contribution. Person Responsible: Will Nabih To be implemented by: 30 Sep 2021	**12 Apr 2021** JC - recruitment underway	

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30/09/2020	BAF 6	There is a risk of not providing robust digital infrastructures and defences against cyber security. Also the ability of the Trust to provide and use reliable data (business intelligence), making best use of technology is compromised. Executive Lead: James Drury Operational Lead: Rebecca Gallimore Last Updated: 23 Apr 2021	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure	Hazard(s) / Cause(s): Unable to deliver excellent patient outcomes and maintain financial and operation sustainability due to a failure to develop and embed a robust Clinical IT Strategy. Effect(s) & Impact(s): Potential to lead to inefficiencies financially and technically, causing further financial pressure on the Trust and the potential for patient harm. A failure to ensure appropriate investment in and application of digital defences to deter cyber-attacks may lead to patient harm; financial loss; and disruption and/or damage to the reputation of the Trust from the failure of information technology systems.	Finance & Performance	I = 4 L = 4 16	I = 4 L = 3 12	• Information Governance Assurance Framework (IGAF) Digital Strategy • Infrastructure Review • Cyber security review Control Owner: Rebecca Gallimore	• Cyber security tools procured to support access management, asset management, security compliance, single sign on • Additional security staff training • Digital Programme Board • Additional data warehouse technical support from MLCSU to drive data automation and reporting	• CARECERT updates • Major incident plan in place • Network accounts checked after 50 days of inactivity – disabled after 80 days if not used • Spam and malware email notifications circulated • Password and access policy updates	• Periodic phishing exercises carried out by MIAA • Dionach assessments • Due diligence reivews (infrastructure, network, data warehouse, Windows 10) • Audit review of DSPT	• All due diligence reviews complete, recommendations being implemented	Adequate Assurance Date: 23 Apr 2021 Assurance By: Tony Holt	Align Medical Records Strategy with EPR ambition Person Responsible: Rebecca Gallimore To be implemented by: 31 Mar 2022	**23 Apr 2021** RG: Ashley May, CCIO, now chair of the Medical Records Committee, strategy alignment in progress	I = 4 L = 2 8
														Complete Trust-wide Windows 10 upgrade Person Responsible: Rebecca Gallimore To be implemented by: 31 Mar 2022	**23 Apr 2021** RG: Windows 10 roadmap and rollout in progress with all Divisions	
														Implementation of procured security applications and tools Person Responsible: Rebecca Gallimore To be implemented by: 31 Mar 2022	**23 Apr 2021** RG: Funding secured in March 20/21, implementation underway.	
														Prioritisation & assessment of IT projects currently in flight through to early stages of working up, in context of team capability and capacity Person Responsible: Rebecca Gallimore To be implemented by: 31 Dec 2020	**23 Apr 2021** RG: Trust digital priorities agreed, Roadmap approved and resource implications under review. Divisional Digital Roadmaps in progress	

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30/09/2020	BAF 7	There is a risk of not delivering expected and planned transformational service redesign (HTP). Executive Lead: Chris Preston Operational Lead: To be allocated Last Updated: 15 Apr 2021	We work closely with our patients and communities to develop new models of care that will transform our services	Hazard(s) / Cause(s): A failure to provide future-proof and fit-for-purpose excellent patient outcomes and achieve financial and operational stability through the lack of direction and control Effect(s) & Impact(s): That could potentially result in patient harm and reputational damage due to incorrect results, lack of services and significant delays.	Finance & Performance	I = 5 L = 5 25	I = 4 L = 3 12	Transformation Plan • Programme resources in place • HTP timeline for delivery revised and agreed • Project governance revised and agreed Control Owner: Chris Preston	• Appointment of Director of Transformation & Strategy and Associate Director of Transformation • Performance Reporting to Assurance and Management Committees	• Director of Transformation & Senior team established • New HTP Programme Board • Acceleration of HTP clinical pathway development	• 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 • Overview, Scrutiny from NHSE/I • Partnership agreement with UHB	• Draft SOC not approved • Continued commitment to deliver main elements of Future Fit • Funding to be sourced regionally - not on national programme • Re-engagement with MPs and stakeholders and associated communications to be re-established	Limited Assurance Date: 15 Apr 2021 Assurance By: Tony Holt	Finalise and submit revised SOC after re-examining costs Person Responsible: Chris Preston To be implemented by: 30 Jun 2021		I = 5 L = 3 15
														Review options for multi-story car parking and Energy Centre Person Responsible: To be allocated To be implemented by: 31 Dec 2020		
														Review options including inflation costs and scope Person Responsible: To be allocated To be implemented by: 30 Dec 2020	**15 Apr 2021** CP - Independent review undertaken Jan-21	

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30/09/2020	BAF 8	There is a risk of not adequately meeting CQC Health & Social Care regulations. Executive Lead: Hayley Flavell Operational Lead: Kara Blackwell Last Updated: 09 Apr 2021	Our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care	Hazard(s) / Cause(s): Non -compliance in achieving Trust strategic objectives due to failing to consistently meet the requirements of the CQC Health & Social Care regulations or other national standards. Effect(s) & Impact(s): May lead to regulatory action being taken against the Trust, compromising patient care and reputational damage.	Quality and Safety	I = 4 L = 5 20	I = 4 L = 4 16	Clinical and Corporate service accountability in place Control Owner: Hayley Flavell	• Exemplar Programme • Weekly sisters meetings with DoN • Monthly Matron's meeting • Confirm & Challenge meeting	• QOC • QSAC • Board of Directors meeting • RALIG • NIQAM • Rapid Review process • Patient Experience Group • Mortality Group • Deteriorating Patient Group • IPC Committee • Safeguarding Assurance Committee	CQRM		Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt	Plan to present a number of section 31 conditions to CQC with a view to having them lifted. Person Responsible: Hayley Flavell To be implemented by: 30 Apr 2021	**09 Apr 2021** HF: Provided evidence and rationale to CQC to remove 11x s31 conditions	I = 4 L = 2 8
														Develop and implement mock CQC inspections Person Responsible: Kara Blackwell To be implemented by: 30 Sep 2021		
								Increased engagement and wider system oversight. Control Owner: Hayley Flavell	• Nursing, Midwifery & AHP Group • Corporate Senior Leadership meeting • SLC-O • Quality Compliance & Regulatory Steering Group • Safeguarding Operational and Assurance Committees • EOL Committee • Confirm & Challenge meeting • CQC monthly engagement meeting	• QOC • QSAC • Board of Directors meeting • Getting to Good programme	• SOAG • CQRM • CQC engagement • Comittees in Commonfrom Improvement Alliance		Adequate Assurance Date: 05 Mar 2021 Assurance By: Tony Holt	Plan to have all conditions lifted is on track to deliver by 30 Sep 2021 Person Responsible: Hayley Flavell To be implemented by: 30 Sep 2021		
														Ensure QOC has oversight of key themes and programmes and work. Person Responsible: Kara Blackwell To be implemented by: 30 Sep 2021		
														Standardising Divisional Governance meetings Person Responsible: Anna Milanec To be implemented by: 30 Sep 2021		
								Strengthened Corporate Governance Structure. Control Owner: Anna Milanec	Divisional and specialty governance meetings	• QOC • QSAC • Board of Directors	NHSI/CQC oversight	Standardised work programmes and information still requires development	Limited Assurance Date: 05 Mar 2021 Assurance By:	Structured oversight/review of s29 and s31 reporting ownership and responsibilities supported by PMO with Corporate Nursing ownership Person Responsible: To be allocated To be implemented by: 30 Dec 2020		

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30/09/2020	BAF 9	There is a risk that the impact of COVID-19 continues to affect the Trust's quality outcomes and targets Executive Lead: Arne Rose Operational Lead: To be allocated Last Updated: 12 Jan 2021	Our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care	Hazard(s) / Cause(s): • no significant reduction in the volume of Covid-19 patients within the hospitals • the known impact of winter/service pressures Effect(s) & Impact(s): • continuing cancellation of routine work and growing elective lists • negative effect on acute services and patient outcomes	Quality and Safety	I = 5 L = 4 20	I = 5 L = 3 15	Cohorting plans in place Control Owner: To be allocated	Extensive monitoring at operational and strategic levels: • Daily sitrep report • Emergency and Resilience Plan and Group Meeting • Approval through Gold Command	• Incident Room reports • Plans agreed/funding secured to increase capacity	Opening of new wards in progress		Adequate Assurance Date: 10 Dec 2020 Assurance By: Tony Holt	Estate capacity submission to NHSI/E re: RSH ED/SDEC, Modular ward capacity, Mobile diagnostic unit(s). Person Responsible: To be allocated To be implemented by: 31 Dec 2020		I = 5 L = 2 10
														Q4 whole system capacity and demand forecasting Person Responsible: To be allocated To be implemented by: 04 Jan 2021		
								Infection Prevention & Control training ongoing programme in place Control Owner: To be allocated	IPC compliance report to QSAC monthly	•Health/Safety related Policies/ Procedures in place •Staff training in place and compliance rates reported to QSAC •Infection control annual plan developed in line with the Hygiene Code	•Advanced Training in National guidance •IPC programme approved at QSAC •Environmental cleaning audits		Adequate Assurance Date: 10 Dec 2020 Assurance By: Tony Holt	Vaccination Programme - vaccination hubs across Shropshire established and operational Person Responsible: To be allocated To be implemented by: 29 Jan 2021		
								Stabilised PPE delivery and effective deployment Control Owner: To be allocated	Regular quantified PPE report from Medical Director circulated to all staff	PHE oversight/regular reporting			Adequate Assurance Date: 10 Dec 2020 Assurance By: Tony Holt			
								Vaccination programme commenced Control Owner: To be allocated	Angie Wallace leading programme	County-wide 'vax-hubs' established	LHE-wide reporting of progress against targets		Limited Assurance Date: 10 Dec 2020 Assurance By: Tony Holt			

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02/10/2020	BAF 10	There is a risk around the uncertainty of Brexit Executive Lead: Nigel Lee Operational Lead: To be allocated Last Updated: 12 Jan 2021	We deliver safe and excellent care, first time, every time	Hazard(s) / Cause(s): Potential for UK to leave EU without a deal Effect(s) & Impact(s): Disruption to procurement and HR	Finance & Performance	I = 4 L = 3 12	I = 4 L = 2 8	Communication with NHS. Awaiting Guidance with respect to: • Workforce • Medicines • Equipment Control Owner: To be allocated	Workforce updates flag potential issues to Assurance Committees	Procurement team closely monitoring and flagging any changes in national position.		Uncertainty around emerging 'no deal' scenario		Action 1 Person Responsible: To be allocated To be implemented by: 31 Dec 2020		I = 4 L = 2 8

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23/02/2021	BAF 11	There is a risk of prolonged and/or substantial failure to deliver standards of maternity and neonatal care. Executive Lead: Hayley Flavell Operational Lead: Last Updated: 22 Apr 2021	We deliver safe and excellent care, first time, every time	Hazard(s) / Cause(s): Inconsistencies in care relating to: - Safeguarding Patients - Avoidable perinatal mortality and morbidity - Infection Prevention and Control - Antenatal, Intrapartum and postnatal care pathways - Early booking - Infant Nutrition - Patient Experience - Antenatal and newborn screening - Provision of 1:1 care in labour - Provision of bereavement care - Perinatal mental health Effect(s) & Impact(s): The Trust may not meet these standards due to: -Inconsistencies in clinical pathways -Incomplete training and competencies -Inconsistencies in governance arrangements -Inability to recruit and retain the right numbers and skill mix of nursing staff -Individual substandard practice of registered health professionals -Timeliness and quality of decision making and escalation -Unwillingness to raise concerns -Failure to learn from incidents and make sustained improvements -Capacity and..	Quality and Safety	I = 5 L = 4 20	I = 5 L = 3 15	Corporate Induction and ongoing mandatory and role specific training for all staff outlines required standards of practice and care. Control Owner: Rhia Boyode	Exemplar Programme		Clinical audit programme & monitoring arrangements	Not achieving required levels of training.	Limited Assurance Date: 23 Feb 2021 Assurance By: Tony Holt	Develop CREWS Board and weekly meeting for local monitoring of performance data Person Responsible: Nicola Wenlock To be implemented by: 28 May 2021		I = 5 L = 2 10
								Internal policies and procedures detail the required standards and practice for maternity care. Control Owner: Nicola Wenlock		QSAC, chaired by NED, receives monthly assurance reports from steering groups responsible for the following areas: -Infection Prevention and Control -Patient Experience -MQOC	Quality Improvement Programme with system and regulatory oversight group	• Variable quality of incident review leading to late identification of SIs	Limited Assurance Date: 23 Feb 2021 Assurance By: Tony Holt	Review of Quality Governance and assurance Person Responsible: Nicola Wenlock To be implemented by: 30 May 2021	**22 Apr 2021** CH: Interim Director and Ass. Director level support in post	
								Maternity metrics that routinely monitor standards of care. Control Owner: Nicola Wenlock	.	Safe staffing report submitted to Public Board of Directors in line with CNST MIS safety action 5 meeting		• Incidents not all reviewed in timely manner due to capacity within team • No local oversight of performance	Limited Assurance Date: 23 Feb 2021 Assurance By: Tony Holt	Implement NBCP fully across all areas Person Responsible: Nicola Wenlock To be implemented by: 31 May 2021		
														Gap analysis against CQC core assessment framework Person Responsible: Nicola Wenlock To be implemented by: 31 May 2021		
								Maternity Transformation Programme Control Owner: Hayley Flavell						Develop patient engagement strategy Person Responsible: Nicola Wenlock To be implemented by: 31 May 2021		
								Reporting and Management of Incidents via Datix provides a route for all staff to raise concerns and report issues. Control Owner: Nicola Wenlock	The service level meetings eg. PMRT meeting monitor compliance and performance with standards, ensure issues/incidents are recognised, acted upon, reported and lessons are learnt and shared.			• Variable quality of incident review leading to late identification of SIs • Incidents not all reviewed in timely manner due to capacity within team	Limited Assurance Date: 23 Feb 2021 Assurance By: Tony Holt	Complete Action Plan for Independent Maternity Review emerging trends Person Responsible: Nicola Wenlock To be implemented by: 31 May 2021		
								Ward level quality dashboards that provide real time data in relation to standards of care. Control Owner: Nicola Wenlock	Weekly MDT risk meeting to review all incidents	MQOC, cheired by DoN - receives monthly reports detailing - dashboard - staffing - PMRT - Workforce - MIP - MTP		• Variable quality of incident review leading to late identification of SIs • Incidents not all reviewed in timely manner due to capacity within team	Limited Assurance Date: 23 Feb 2021 Assurance By: Tony Holt	Implement LAFL and IEAs as per IMR action plan Person Responsible: Hayley Flavell To be implemented by: 31 Dec		