The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 December 2022

Agenda item	243/22			
Report Title	**Board Assurance Framework – Draft Quarter 2 2022/23**			
Executive Lead	Director of Governance & Communications – Anna Milanec			
Report Author	Interim Governance Consultant – Deborah Bryce			
	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:	2022.10.25 Finance and Performance Assurance Committee 2022.10.26 Quality and Safety Assurance Committee 2022.11.30 Audit and Risk Assurance Committee			
Executive summary:	The Board Assurance Framework (BAF) content has been refreshed for Quarter 2, 2022/23 by the executive risk owners. This includes updates to progress with the actions associated with gaps in control and assurance. The current risk score of risk 12 is proposed to be increased from 4x3=12 to 4x4=16 within Quarter 2. **Recommendation(s):** The Board is asked to consider if the BAF content and risk scores reflect the strategic risks within the organisation and approve the Quarter 2 BAF for 2022/23.			
Appendices	Appendix 1: Draft Board Assurance Framework – Quarter 2 2022/23			
Executive Lead				

1.0 Introduction

1.1 The Board Assurance Framework (BAF) outlines the risks to achievement of the organisation's strategic objectives.

1.2 Work to review and refresh the quarter 2 BAF content was undertaken towards the end of September and in early October 2022, following on from the quarter 1 BAF content which was agreed by Board on 11 August 2022.

1.3 The Board is reminded that the initial risk score of BAF 11 for quarter 1 was agreed to be increased by Board in August 2022 from 4x4=16 to 5x4=20. This score has been updated within the quarter 2 BAF.

1.4 The Finance & Performance Assurance Committee and Quality and Safety Assurance Committee considered the draft quarter 2 BAF on 25 and 26 October, respectively. Useful comments were received from a Non-Executive Director following a committee meeting in relation to the assurances outlined within the BAF, in particular potential further 3rd lines of assurance (external or independent assurances). These comments will be discussed and considered with the executive risk owners within the quarter 3 BAF production.

2.0 Significant changes to the BAF in quarter 2 2022/23

2.1 The BAF narrative with regards to progress of actions associated with gaps in control and assurance have been significantly refreshed in quarter 2. Additional narrative is shown in blue text within the draft BAF in **Appendix 1**, including some updated timescales.

2.2 The current risk score of BAF risk 12 (*There is a risk of non-delivery of integrated pathways, driven by the ICS and ICP*) which is overseen by Quality & Safety Assurance Committee is proposed to be increased from 4x3=12 to 4x4=16 within quarter 2. This proposed increase is due to the work being outside the control of the organisation (as the Trust supports the work).

2.3 There are no other changes proposed to risk scores in quarter 2 by the executive risk owners.

2.4 With regard to BAF risk 6 (*some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose*), gap in control number 1 and gap in assurance number 5 are proposed to be closed as they are no longer perceived to be gaps within quarter 2.

2.5 In relation to risk actions, three additional actions (aligned with gaps in control) have been added within BAF risk 1 and two actions within BAF risk 2. There has also been discussion with regards to the overlaps within BAF risks 1 and 2 and the breadth of coverage of these risks.

2.6 Two additional actions have also been added within BAF risk 8 and one within BAF risk 9.

3.0 Risks, actions and the Organisation's Top risks

3.1 The detail of each risk and proposed actions aligned with gaps in control and assurance can be seen within the draft quarter 2 BAF.

3.2 Based on the draft current total risk scores for the quarter 2 BAF in 2022-23, there are four top risks with a current total risk score of 20; nine risks with a current total risk score of 16; and one with a score of 15, as indicated within the BAF summary page.

3.3 The four top risk scores, all with a current total risk score of 20 are shown below and remain the same as the four top risks within quarter 1:

The top four BAF risks based on current draft total risk scores at quarter 2:

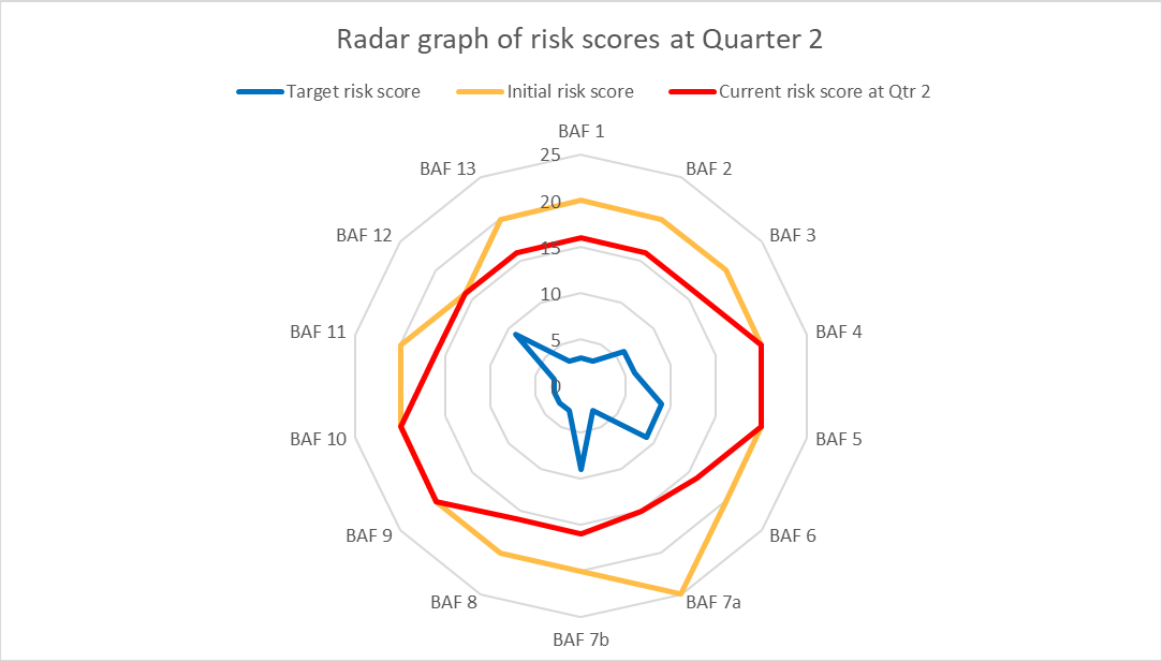
No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 2, 2022-23	Change since quarter 1
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Board	5x4 = 20	No change ↔
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Finance & Performance Assurance Committee	4x5 = 20	No change ↔
BAF 9	The Trust is unable to recover services post-Covid to meet the needs of the community / service users	Finance & Performance & Quality & Safety Assurance Committees	4x5 = 20	No change ↔
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Finance & Performance & Quality & Safety Assurance Committees	4x5 = 20	No change ↔

3.4 Being aware of the proposed top scoring risks (based on the current risk score) should assist the committee/Board to consider if these risks reflect the perceived current top risks within the organisation; the priority of focus given to the risks and assurances received; and consider the comparative scoring of all risks.

4.0 Visual representation of risk scores

4.1 The radar graph within the BAF (below) provides a visual representation of risk scores, including target risk score. It is intended that this will assist the committee/Board to:

- identify the gap between the risk target score and current risk score;
- help identify where the initial and current risk scores are the same (where the line on the graph overlaps), i.e. risks 4,5, 9, 10 and 12, and to consider if the controls are adequate for these risks or if further action and assurance is required; and
- assist to continue to reflect on the target risk scores and whether these remain appropriate.



5.0 Recommendation(s)

The Board is asked to consider if the BAF content and risk scores reflect the strategic risks within the organisation and approve the quarter 2 BAF for 2022/23.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework 2022/23 - draft quarter 2 (July to September 2022)

Updated September-October 2022 (V1.2)

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework 2022/23 - Summary at Quarter 2 (July-September)		Alignment to strategic goal(s)	Initial (inherent) risk score	Target risk score	Lead Executive	Lead Committee	Quarter 3 (2021-22)	Quarter 4 (2021-22)	Quarter 1 (2022-23)	Quarter 2 (2022-23)	Change in current risk score between Q1 and Q2 and further comments
BAF 1	Poor standards of safety and quality of patient care across the Trust may result in incidents of harm and / or poor clinical outcomes	We deliver safe and excellent care first time every time.	5x4 = 20	3	Medical Director /Director of Nursing	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Our high performing and continuously improving teams constantly strive to improve the services that we deliver.	5x4 = 20	3	Dir of Nursing/ Medical Director	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Our staff are highly skilled, motivated, engaged and 'live our values'. SaTH is recognised as a great place to work.	5x4 = 20	6	Director of People & OD	Board	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Our staff are highly skilled, motivated, engaged and 'live our values'. SaTH is recognised as a great place to work.	5x4 = 20	6	Director of People & OD	Board	5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20	No change ↔
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Our services are extremely efficient, effective, sustainable and deliver value for money.	4x5 = 20	9	Director of Finance	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x5 = 20	4x5 = 20	No change ↔
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	4x5 = 20	9	Director of Finance	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	5x5 = 25	3	Director of Finance	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	5x3 = 15	5x3 = 15	No change ↔

Board Assurance Framework 2022/23 - Summary at Quarter 2 (July-September)		Alignment to strategic goal(s)	Initial (inherent) risk score	Target risk score	Lead Executive	Lead Committee	Quarter 3 (2021-22)	Quarter 4 (2021-22)	Quarter 1 (2022-23)	Quarter 2 (2022-23)	Change in current risk score between Q1 and Q2 and further comments
BAF 7b	The inability to replace digital systems impacts upon the delivery of patient care	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	4x5 = 20	9	Director of Finance	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	We deliver safe and excellent care first time every time.	4x5 = 20	3	Director of Nursing	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	No change ↔
BAF 9	The Trust is unable to recover services post-Covid to meet the needs of the community / service users	We work closely with our patients and communities to develop new models of care that will transform our services. We deliver safe and excellent care first time every time.	4x5 = 20	3	Chief Operating Officer	Finance & Performance & Quality & Safety Assurance Committees	5x4 = 20	5x4 = 20	4x5 = 20	4x5 = 20	No change ↔
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is planned.	4x5 = 20	3	Chief Operating Officer	Finance & Performance & Quality & Safety Assurance Committees	5x5 = 25	5x4 = 20	4x5 = 20	4x5 = 20	No change ↔
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	5x4 = 20	3	Director of Strategy & Partnerships	Finance & Performance Assurance Committee	N/A	N/A	4x4 = 16	4x4 = 16	No change ↔
BAF 12	There is a risk of non-delivery of integrated pathways, driven by the ICS and ICP.	We have understanding relationships with our partners, working together to deliver best practice integrated care for our communities	4x4 = 16	9	Chief Operating Officer	Quality & Safety Assurance Committee	N/A	N/A	4x3=12	4x4 = 16	↑ Increased in quarter 2 due to the work being outside the control of the organisation (the Trust supports the work).
BAF 13	Trust-wide services / resources may be further affected by the publicity and negative media attention following publication of the final Ockenden Report.	We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is planned. We deliver safe and excellent care first time every time.	4x5 = 20	3	Director of Nursing and Director of Governance & Communications	Quality & Safety Assurance Committee	N/A	N/A	4x4 = 16	4x4 = 16	No change ↔

The Shrewsbury and Telford Hospital NHS Trust

Risk scoring framework

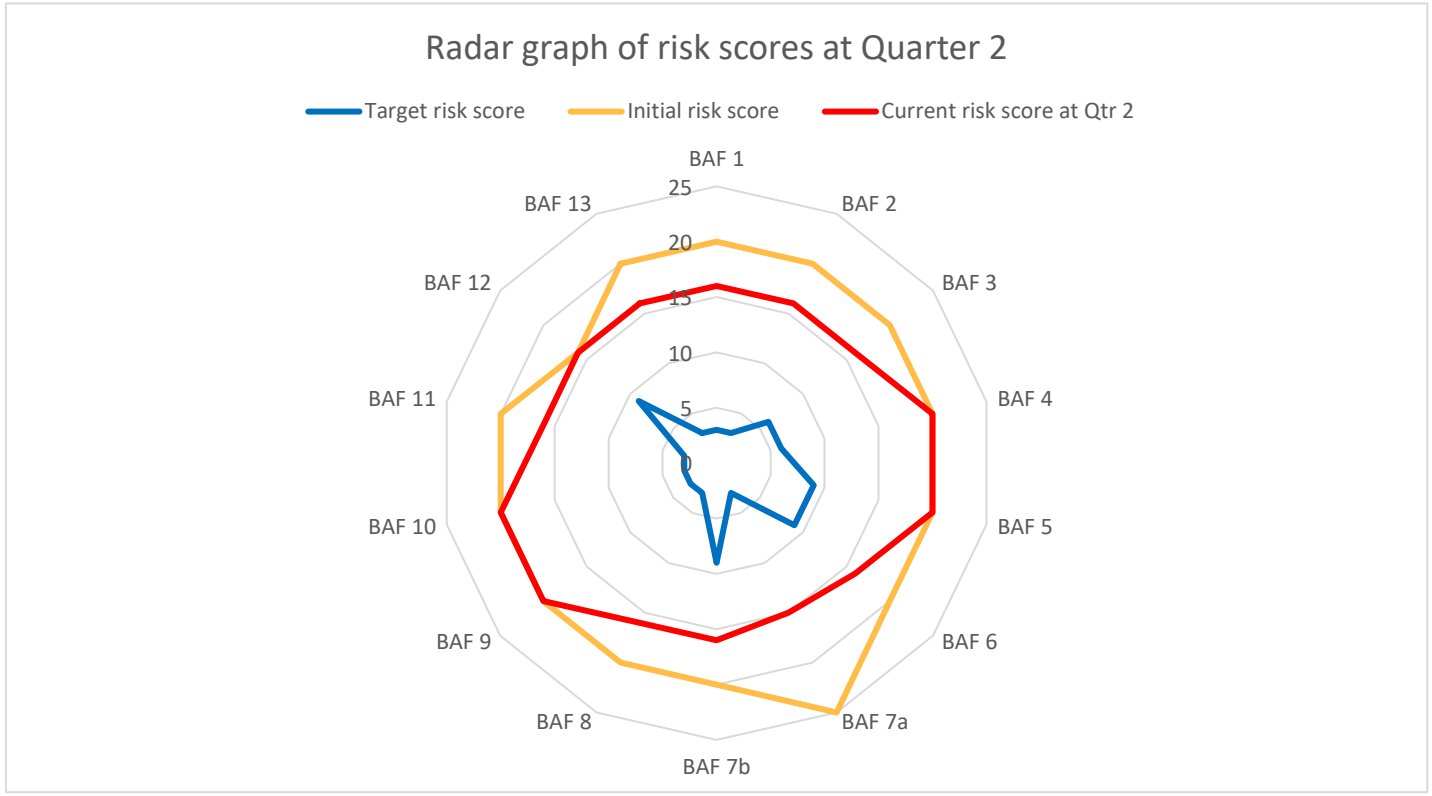
	Likelihood				
	1	2	3	4	5
Impact / consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Severe	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows*:

1 to 3	LOW risk
4 to 6	MODERATE risk
8 to 12	HIGH risk
15 - 25	EXTREME risk

* It may be necessary to review our levels of risk appetite against these scores.

Visual representation of risk scores



Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 1: Poor standards of safety and quality of patient care across the Trust result in incidents of harm and / or poor clinical outcomes.			**Medical Director/ Director of Nursing**	Our patients and community	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Quality & Safety Assurance Committee**					
				Our Governance									
Risk opened: previous risk within 2021/22			John Jones. Hayley Flavell, Richard Steyne	Service Delivery									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Inconsistencies in governance arrangements •Lack of resources •Clarity of standards ~~and frameworks~~ especially where practice may be different across sites •Incomplete training and competencies • Operational pressures • Workforce gaps • Clarity of and consistency in the use of policies and procedures • Covid-19 pandemic • Clarity of quality and integrated governance arrangements • Unable to off-load ambulances in a timely way because of lack of patient flow through the organisation **Consequence:** •Patients at risk of harm • Delays in time critical care • Wrong care • Poor patient experience and increased complaints • Increased length of stay • Deteriorating patients • Reduced staff morale and recruitment and retention • Increased regulatory enforcements •Reputational and financial loss for the organisation	5	4	20	• Getting To Good (G2G) workstreams: Levelling up Clinical Standards and Fundamentals in Care. • Quality Strategy • Clinical audit programme • Digital Strategy • People Strategy • Learning from Deaths Group review • Deteriorating Patient Group • Falls prevention strategy • Safeguarding Policy • IPC Policy • Staff training • Identification and management of concerns about conduct and capability of healthcare professionals • NIQAM /rapid review meetings/ RALIG both in place (NIQAM reviews all pressure ulcers and SI's. Rapid review of all moderate and above incidents) • Quality governance framework within Divisions • Quality Spot check internal audit review • Exemplar programme (ward accreditation) • Monthly Nursing Metrics • Daily incident communications (Datix) • Palliative and End of Life framework • Pressure ulcer panels • Nutrition and Hydration Group • Mental Health and Learning Disabilities Group • Nursing Documentation Group in place	**Reported to Board, committees and elsewhere:** • Mortality metrics reported to Board and Learning from Deaths Group (monthly) (2nd) • Quality metrics within Integrated Performance Report to Board (monthly)(2nd) • Annual Quality Report / Quality Account to committee/Board (2nd) • Learning from Deaths considered by Board quarterly (2nd) • Serious incident reports, themes, claims and complaints report to QSAC and public Board (2nd) • Report on exclusions and restrictions to private Board (2nd) • Quality and Safety Assurance Committee (QSAC) report monthly (2nd) • Quality Operational Committee (2nd) • Performance Review Meetings monthly (2nd) • Monthly G2G Operational Delivery Group meetings - feeding into QSAC and Board (2nd) • Internal Audit Reports (3rd) considered at Audit & Risk Assurance Committee (2nd), e.g. Quality Spot Checks • CQC Report, published November 2021 provides assurance that improvements are being made across the Trust (3rd) • Confirm and Challenge Meetings - monthly (2nd) • Staff Survey results to Board (2nd) • Quarterly pulse surveys considered (2nd) • IPC Assurance Meeting, Maternity Transformation Assurance Meeting, Patient and Carer Experience Panel, Nursing, Midwifery, AHP and Facilities workforce group meeting - reports into QSAC (2nd) • External audit review report (KPMG) of VFM (3rd) • CQC maternity survey - February 2021 (3rd) • Critical Care Executive Oversight Group (2nd) receiving updates on recruitment and safety • Emergency Department Transformation Assurance Committee (ETAC) (2nd)	4	4	16	**Gaps in control:** 1National shortages in specific workforce, e.g. doctors within critical care, care of the elderly, emergency medicine, along with nursing. 2. Insufficient size of emergency assessment areas (at RSH) and gap in sufficient community capacity. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Internal audit review: limited assurance in 2021/22 for: Serious Incidents Management; Complaints Management; and Critical Application review (IC.net). 5. Lack of consistency and stability in leadership at ward and speciality level. 6. Lack of Policies and Procedures Group to sign-off clinical policies, plus no overarching Documentation Group. **Gaps in assurance:** ~~5~~7. Delays in complaints management and Board receiving information.	**Actions aligned to gaps:** 1. NHSE/I supported and executive led review of critical care provision and development of new pathways and recruitment strategies - by December 2022. Executive lead: Medical Director (also see BAF risk 3). 2a. Development of 'medical acute floor' ~~and emergency~~ and initiation of emergency department transformation programme which includes clinical pathways - by ~~October 2022~~ December 2022. Executive Lead: Chief Operating Officer. 2b. Progression of OBC for Hospital Transformation Programme 3. Electronic Patient Record planned by end of 2025. Executive lead: Director of Finance. 4. Progress internal audit report action plans including embedding methodology of learning from complaints and incidents by March 2023*. Executive Lead: Director of Nursing. (*IPC outbreak management module recommendation within critical application report is linked to PAS implementation: Summer 2023) 5. Head of Non-Medical Education introduced Summer 2022. 6. To be discussed with Director of Governance . Executive Lead: Director of Nursing.	1. Work has started. Programme Manager in place - regular updates being provided to Executive Oversight Group. Review of nursing workforce templates completed. 2a. Initial ward moves have been completed to allow estates work to commence. Date extended to December 2022 (from October) 3. Digital roadmap being followed with introduction of Bluespier into theatres and plans for new patient administration system (PAS) to be in place by Summer 2023. 4. Request to extend deadlines for some actions into 2023 made at October ARAC meeting. 4 & 7. Management of complaints was aligned to the Divisional Quality Governance Teams from September 2022. Work is ongoing to embed this process for managing complaints at Divisional level. Further work to cascade the learning from serious incidents across the organisation to staff at all levels is underway.			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 2: The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.			**Director of Nursing/ Medical Director**	Our patients and community	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Quality & Safety Assurance Committee**					
				Service Delivery					j				
Risk opened: previous risk within 2021/22			Hayley Flavell	Our partners									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Inconsistencies in care, which may apply to any patient. • Workforce gaps (including vacancies) • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies •Inability to recruit and retain the right numbers and skill mix of nursing staff • Lack of consistency and lack of clarity of standards • Increase in use of temporary and agency staff • Lack of consistency in senior leadership historically • Lack of clarity of data and triangulation of data **Consequence:** • Inconsistencies in governance arrangements • Poor patient experience • Increased complaints • Poor reputational damage • Lack of confidence in the organisation • Not an open and honest culture • Increased harm • Further CQC prosecutions and enforcements if standards and frameworks are not in place.	5	4	20	• Getting To Good (G2G) workstreams: Delivery of the Quality Strategy 2021-24; Maternity Transformation; Quality Governance (including PMO plans to deliver the 8 'themes', Levelling up quality standards • Quality Strategy • Complaints Process • Freedom to Speak Up arrangements • Quality Operational Committee • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Genba visits • Exemplar programme (ward accreditation) • Monthly quality metrics • Quality governance framework within the Divisions • Weekly clinical leaders forum • Newsletters shared • Quality Matrons • Patient Safety Specialist in post • SaTH improvement methodology courses • SaTH Improvement Hub • Clinical Lead for Improvement appointed (May 2022)	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) • Quality and safety metrics within Integrated Performance Report to Board (monthly) (2nd) • ORAC - Ockenden Report Assurance Committee (2nd) • Internal audit reviews - Quality Spot Checks and Complaints Management (3rd) • Maternity Transformation Assurance Committee (2nd) • Culture dashboard reported to Operational People Group (1st) • Metric meetings, Quality Operational Meeting (1st) • Falls Steering Group (1st) • Palliative End of Life Care Steering Group (1st) • Pressure Ulcers Group (1st) • Operational Groups - IPC, Safeguarding (children and adults) (1st) • Assurance groups: IPC, safeguarding and maternity which feed into QSAC (2nd) • NIQAM (nursing incidents quality assurance meeting) - monthly (1st) • RALIG (review and learning from incidents group) - weekly (1st) which feeds into QSAC and Board • Rapid review - weekly (1st) • Weekly Getting to Good review meetings (1st) • CQC Report, published November 2021 provides assurance that improvements are being made across the Trust (3rd). • Monthly reports to Quality Operational Committee (1st) • Flow Improvement Group (1st).	4	4	16	**Gaps in control:** 1. Robust risk management reporting/processes. 2. Lack of out of hours standardisations - 15 steps. 3. Following up serious incident review action plans. 4. Delayed complaints, including backlog of complaints, sharing learning from complaints across the organisation and limited assurance provided in internal audit complaints management review. 5. Potential lack of capacity in ~~Corporate Nursing Team~~ within the Divisions, including ownership, to support delivery of Quality Strategy at pace. **Gaps in assurance:** 6. Information/KPI's to indicate quality strategy is being delivered.	**Actions aligned to gaps:** 1a. Introduce Datix risk management system in June 2022 across the organisation. Executive Lead: Director of Nursing. 1a. New process for highlighting immediate actions following RALIG - September 2022. Executive Lead: Medical Director 2. Develop a process to support out of hours visits - by December 2022. Executive Lead: Director of Nursing. 3. Hold weekly meetings with the Quality Governance Team and Divisions to track SI actions and monthly meetings with the ICS, CSU and Quality Governance Team to review all SIs and actions throughout 2022-23. Executive Lead: Director of Nursing. 4. Consider how align complaints with the quality governance framework by December 2022. Executive Lead: Director of Nursing. 5.There are leads for each of the 8 priorities within the Quality Strategy. Track implementation of the priorities through the various steering groups e.g. PEOLC, Falls, Deteriorating Patient, Vulnerable Patients - by March 2023. Executive Lead: Director of Nursing 6a. Develop quality strategy dashboard by December 2022. Executive Lead: Director of Nursing 6b. Review of reporting to and functioning of Quality Operational Committee (QOC) by December 2022. Executive Lead: Medical Director.	1a. Completed Q1 1b. First alert relating to effects of drugs on heart rhythm circulated September 2022. 2. Draft Process has been developed for agreement by CEO/DON - ongoing. 3. Complete (Q1) - meetings being held and will continue to monitor. This action follows the implementation of the Divisional Quality Governance Framework in December 2021 . 4. The Complaints Team will now be managed by the Quality Governance Team and aligned with the Divisions in relation to support from Sept 2022. Arrangements have just begun, but are in their infancy. 5. This is ongoing with reporting on progress through the Steering Groups and ODG (Operational Delivery Group) 6. This dashboard development had a previous target completion date of March 2022 but has been delayed due to a lack of capacity in the Performance Team to develop and support ongoing reporting. The dashboard needs to be developed at pace as it is difficult to track progress without the robust data. One meeting has been held to discuss how to develop and align information so far. Completion date to be re-considered as may not be completed by December 2022. 6b. Medical Director and Deputy Medical Director have begun work with Divisions to improve quality of QOC papers.			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee						
BAF 3: If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and on the quality of care.			**Director of People & OD**	Our People	**SATH has a MODERATE risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure that we are an employer of choice.**			**Board**						
				Our patients and community										
Risk opened: previous risk within 2021/22			Rhia Boyode (RB)	Service Delivery										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Failure to recruit and retain the right number of people at the right level, with the right skill mix. • Retirement remains as a leading reason for staff turnover • Staff fatigue burnout. Stress, anxiety, and depression remains a top reason for long term sickness • Some staff who are homeworkers reporting isolation in mental health • Lack of certainty around future ways of working and work environments • Shortage of key professionals and occupations in specific roles • Lack of succession planning to mitigate risks when key staff leave and encourage staff retention **Consequence:** • Staff dissatisfaction with the level of engagement, involvements and communication with team leaders and senior leadership leading to low morale • Poor levels of engagement and morale which are correlated with lower patient satisfaction and outcomes • High use of agency staff. • High levels of sickness and turnover. • Disruption to services. • Poor patient experience and outcomes. • Adverse publicity and/or reputational damage. • May lead to the financial unsustainability of some services.	5	4	20	• People governance arrangements in place including Operational People Group and ICS Retention Group (monthly) • Dashboards reporting against People Strategy, action plans and KPI's • Diversity, Equality Inclusion plan and Recruitment and Retention plan supporting it. • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff survey, pulse survey, workforce transformation ICB/ICS programmes such as HCSW and Talent programme, improve well and making a difference linked to the culture dashboard. • Enabling programmes in place with escalation/assurance to OPG/SLT/FPAC and QSAC committee through to People board where indicated. • Extensive Health & Wellbeing (HWB) programme including staff finance, support, physio, clinical psychology and therapy • Culture, respect and inclusion programmes • Leadership development framework • Working group in place engaging with workforce to create a plan new way of working alongside estate and digital plans to support. • Regular meetings with new starters with a member of the executive team, this is with the People and OD Director and for Nursing and Allied Health Professionals is with Director of Nursing • International recruitment programme in place for nurses - recruited 197 in 2021/22. • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Introduced a range of new programmes such as a Nursing Associate Top Up programme allowing development of Nursing Associates to become registered nurses. • Safer Recruitment and Selection workshops have been implemented to support appointing managers during the hiring process. • Development of the integrated ICS Workforce Plan	**Reported to Board, committees and elsewhere:** • Reports to Board People Committee and Operational People and Educational Group (OPG) (2nd) • Daily and weekly reports on workforce metrics, temporary staff usage, and agency spend considered (1st). • Annual Staff survey considered by Board along with updates (2nd) • People Strategy approved by Board (2nd) • Equality, Diversity & Inclusion Strategy approved by Board (2nd) • Recruitment & Retention Strategy progress approved/received by the Board (2nd) • Quarterly Staff Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at OPG (2nd)	4	4	16	**Gaps in control:** 1. Systematic process throughout the Trust to support staff development, and career progression. 2. Embedded processes for medium- and long-term workforce planning mechanisms with links to transformation/Hospital Transformation Programme. 3. Continued work required to deliver new ways of working/smarter working for corporate teams – scoping impact of risks 4. Managing Working Time Directive breaches and management of rosters for medical staff 5. Workforce strategy to be refreshed for clinical, corporate, and medical professions 6. Reward and recognition schemes 7. Talent management plan 8. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS people plan **Gaps in assurance:** 9. Consistent, regular workforce data reported to relevant groups and committees	**Actions aligned to gaps:** Executive Lead for actions: Director of People and Organisation Development. 1. Develop management technical competency framework for bands 3 to Board - launch by December 2022. 2a. Full internal audit of the workforce planning process by October 2022. 2b.Workforce planning process/annual cycle with a five-year time horizon by December 2022. 3. Support corporate staff to work differently in a hybrid model, develop a short, medium- and longer-term plan that delivers workforce, estates and financial benefits by March 2023. 4. Implementation of the people services improvement plan by August 2023 which includes full review of all medical rosters ensuring compliance. 5. Review of people plan strategy with updated actions and performance metrics by July 2023, aligned to the organisation strategy. 6. Development and implementation of refreshed reward and recognition practices across the Trust by March 2023. 7. Embed Scope for Growth programme as part of wider succession planning and talent mapping - by March 2023. 8a. Introduce workforce transformation programme which includes new roles and new ways of working - in place by March 2023. 8b. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure development of staff people plan by July 2023. 8c. Establish and develop psychology hub as part of health and wellbeing plans - by October 2022. 9. Review and agree key workforce performance data, with relevant analysis, for each group and committee by September 2022.	1. On track and to be formally launched in November 2022 as part of Trust Recognition Week 2a. Internal audit completed. b. Workshops are underway with key specialities and departments to review their staffing models and capture workforce requirements. SaTH long-term plans to support our HTP are under development and will capture the workforce requirements over five years. 3. Making a Difference Engagement Platform flexible working conversation completed in May 2022. Feedback from this and immediate actions to be rolled out October 2022. Work is due to commence to review the Agile Working Policy. 4. Work in progress and on track. 6. Now have annual recognition plan in place. Review of benefits work is ongoing. 7. Ongoing 8b. Commenced review of health and wellbeing framework diagnostic tool - on track. 8c. Lead consultant joined trust 1 September. To recruit to team. Scoping current services and design of future services. Psychological services contract extended until end of December 2022. 9. Action completed in relation to availability of information. Plus, ongoing work to review workforce dashboards and align to ICS metrics. Key workforce metrics are reported to OPG with relevant analysis aligned to NHS People Plan. Launch of the Workforce Reporting Hub planned for October and provides detail of key workforce metrics.	3	2	6

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.			**Director of People and OD**	Our People	**SATH has a MODERATE risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure that we are an employer of choice.**			**Board**					
				Our patients and community									
Risk opened: previous risk within 2021/22			Rhia Boyode	Service Delivery									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • ~~Resources in quality improvement training and~~ Engagement in quality improvement initiatives due to competing demands on the team. • Redeployment of staff to support operational activity, reducing the opportunity of staff to be involved in improvement activity or take part in training. • Failure to address inequalities across all protected characteristic groups of staff in terms of promotion, career progression and over representation of staff from minority ethnic groups in formal HR processes. • Leadership styles that do not reflect the Trust values and behaviours framework • Colleagues not accessing appropriate learning and development, including statutory and mandatory training **Consequence:** • The trust's reputation will be compromised impacting on recruitment and retention • Failure to embed and model the values and behaviours of the trust consistently and create confidence in speaking up culture and processes. • Leadership roles not reflecting diverse nature of community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes • Turnover and sickness absence will remain above target • Potential incidents if staff are not up to date with mandatory training • Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience, and with attendant risks around staff motivation, morale and productivity.	5	4	20	• Educator role for newly qualified nurses (visible role picking up pastoral and education needs) • Equip people to deliver quality improvement locally, to identify and embed organisational learning to provide a positive impact on quality of care • Board and workforce equality committee dashboards reporting against strategy, action plans/KPI's and inclusion plan • Workforce metrics, staff survey, pulse surveys, EDI (equality, diversity and inclusion) groups, staff networks, triangulation of data, coaching methodology, SaTH improvement methodology • Participation in WRES (workforce race equality standard), WDES (workforce disability equality standard), EDS (equality delivery system) frameworks and gender pay gap reporting • Minority ethnic staff leadership programmes • ICS BAME Programme • Values based recruitment approach • Agreed targeted recruitment campaigns and retention actions including exit interviews • Targeted interventions on statutory and mandatory training compliance, using Pareto analysis • Learning Made Simple reporting on statutory and mandatory training compliance • Target interventions on culture dashboard metrics, using Pareto analysis • External Executive Directorship Training provided to first cohort May/July 2022 • Civility Saves Lives programme roll out • Launched SaTH education offer via education prospectus	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People Board (2nd) • Operational People Group, monthly (1st) • Education Group (1st) • System education/training meeting (1st) • Culture dashboard to Operational People Group (1st) • Getting to Good progress reviewed/reported monthly (2nd) • Annual Staff Survey considered by Board (2nd) • Workforce data on leadership profile (1st) • Recruitment dashboard (1st) • Senior Leaders Committee - operational, monthly (2nd) • Culture Group established to review culture dashboard, monthly (2nd) • People Pulse Surveys reported to OPG quarterly (2nd) • EDI reporting into EDI Performance Group, which feeds into OPG (2nd)	5	4	20	**Gaps in control:** 1. Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place 2. Ongoing improvements to ensure that learning and changes in practice are fully embedded - incidents, complaints, serious incidents and claims 3. New ways of working 4. Leadership reporting band 3 to Board 5. Lack of systematic approach to talent management and succession 6. Head of Medical Education gap 7. Embedding of trust values and consistently at every level and within all key systems and processes 8. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Director of People and Organisation Development. 1. Embed stay conversations and review and refresh exit interview process - by December 2022 2. To provide our people with the tools and coaching to support innovation, quality improvement and Organisational learning via the SaTH Improvement Hub - ongoing work throughout 2022/23 and ongoing. 3a. Support corporate staff to work differently in a hybrid model, develop a short, medium- and longer-term plan that delivers workforce, estates and financial benefits by March 2023. 3b. Introduce workforce transformation programme which includes new roles and new ways of working - in place by March 2023. 4. Regular monthly reporting of leadership development through to Operational People Group from September 2022. 5a. Embed Scope for Growth programme as part of wider succession planning and talent mapping - by March 2023. 5b. Develop management technical competency framework for bands 3 to Board - launch by December 2022. 5c. Deliver and evaluate the Leadership & Development Strategy and Programme for compassionate, inclusive and effective leadership - by March 2023. 6. Agree/discuss with Medical Director on 25/7/22 meeting; discuss at Education Group 27/7/22; report at Board in August via Education & Improvement Report. Business case, as required by December 2022. 7. Communication to re-energise vision, values and behavioural framework by March 2023 8. Deliver EDI action plan and review against key workforce data by December 2023	1. Reviewing use of ESR as a platform to capture exit interview data. Reviewing process and existing avenues to capture staff thoughts if dissatisfied. 2. Working through national PSERF guidance in relation to how we react to incidents nationally. Improvement Hub supporting this work. 3. Making a Difference Engagement Platform flexible working conversation completed in May 2022. Feedback from this and immediate actions to be rolled out October 2022. Work is due to commence to review the Agile Working Policy. 4. Reporting and action completed September 2022. 5a. Ongoing 5b- . On track and to be formally launched in November 2022 as part of Trust Recognition Week 6. Discussed with Medical Director and at Education Group. Business case is under preparation. Funding source has been agreed for this post. 7. On track. Review of current process and policies is due to commence in the quarter 3. 8. EDI Performance Group meets bi-monthly to track progress against plans, with bi-annual plans to Board (WRES and WDES to Board in October).			6

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 5: The Trust does not operate within its available resources, leading to financial instability and continued regulatory action.			**Director of Finance**	Our service delivery	**SATH has a HIGH risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring that we minimise the possibility of financial loss and comply with statutory requirements.**			**Finance & Performance Assurance Committee**					
				Our governance									
Risk opened: previous risk within 2021/22			Helen Troalen	Our Partners									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: •Overspend against operational budgets driven by operational pressures •Under-delivery of CIP • Capital constraints •Historic under-investment driving increased capital requirement •A failure to maintain financial sustainability due to non-planned cost pressures • Lack of available appropriate substantive workforce **Consequence:** •Short-term recovery inhibits service quality improvement. •Dwindling cash reserves. •External action being taken against the Trust (in segment 4 of System Oversight Framework) • Continue imposition of regulatory controls leading to the loss of local control. •Damage to the Trust's reputation and the Trust's continuing abilities to function	4	5	20	• Getting To Good (G2G) workstreams: Productivity & Efficiency; Financial Literacy; Financial Reporting & Planning; Power BI (business intelligence) & Performance. • Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system - budget holder to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Efficiency and Sustainability Group • Executive led financial governance group - meets weekly to consider controls on committing expenditure • Annual revenue plan for 2022/23 that was developed with specialty input and within which activity, workforce and finance triangulate (1st)	**Reported to Board, committees and elsewhere:** • Monthly Trust-wide finance reports to Board of Directors, FPAC and Financial Governance Group (2nd) • Sustainability and Efficiency (CIP) report to Innovation & Investment Committee and Senior Leadership Committee-Operational (2nd). • Annual financial plan, planning progress shared with Board for sign off (2nd) • Divisional Performance Review Meetings (PRM), Cascade, Executive messages into the organisation (2nd). •Monthly performance reviews with divisions (1st) •Weekly G2G review meetings - finance improvement actions reported (1st) • Routine monthly reporting including variance to plan and run rate analysis (1st) • Internal audit reports (MIAA): core financial controls and sustainability and efficiency processes (3rd) • Report to region (NHS Midlands) each month and position shared with local Integrated Care Board (2nd). • External audit of annual accounts (3rd) • Workforce plan reported to Operational People Group (1st)	4	5	20	**Gaps in control:** 1. Divisions have lack of capacity to engage in their basic budget holder responsibilities, to participate in effective sustainability and efficiency planning. 2. Adherence to cost control policies and processes under times of extreme operational pressure. 3. Financial acumen both within the finance department and across the organisation. 4. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 5. Risk management process that takes into account quality and safety risk alongside financial risk leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost. 6. Lack of activity based five year financial plan **Gaps in assurance:** 7. Evidence of effective budget surgeries (monthly meetings to review budgets)	**Actions aligned to gaps:** 1a. Re-invigorated monthly PRM process - started on 8th July 2022. Lead Executive: Chief Operating Officer. 1b. Identify trust-wide savings initiatives that reduce the dependency on divisions to identify heroic savings plans - by June 2022 (delivery by end of March 2023). Executive Lead: Director of Finance 1c. Engage divisions in a realistic multi-year cost improvement efficiency pipeline - by September 2022 (and by March 2023 for 2023-24 financial plan). Executive lead: Director of Finance. 2a. Weekly executive led Finance Governance Group (FGG) - started June 2022 and to be functional by September 2022. Executive lead: Director of Finance. 2b. Implement the recommendations from nationally commissioned internal audit exercise - TBC, once details of the exercise are made available. Executive lead: Director of Finance. 3a. Deliver training needs assessment and learning programme, use existing resources - by end August 2022. Executive lead: Director of Finance. 3b. Achieve Level 2 Future Focused Finance accreditation (including engagement with divisions) - by end December 2022. Executive lead: Director of Finance. 3c. Budget holder training and procurement training trust wide -to be developed by September and delivered by December 2022. Executive lead: Director of Finance. 4a. Implement Oracle 12.2 (finance and procurement system - upgrade) by end September 2022. Executive lead: Director of Finance. 4b. Weekly executive led Finance Governance Group - started June 2022 and to be functional by September 2022. Executive lead: Director of Finance. 5a. To have a clear process for making investment decisions (both capital and revenue) with clear outcomes shared with those submitting requests for funding. To have a documented business case pipeline. To have consistent documentation and guidance for completing documentation to be issued trust-wide with additional training made available. By September 2022. Executive lead: Director of Finance. 5b. Agreed financial plan that triangulates with the quality improvement plan by March 2023. Executive lead: Director of Finance. 6. Develop activity based five year financial plan by September 2022. Executive lead: Director of Finance 7a. Review of budget holder reports post Oracle 12.2 implementation - by end November 2022. Executive lead: Director of Finance. 7 b. Review of budget surgery agendas and actions log by end January 2023. Executive lead: Director of Finance. 7c. Robust benchmarking of budgets against widely available peer data to inform future budget setting and the efficiency pipeline by March 2023. Executive lead: Director of Finance.	1a. Started. 1b. Trust wide initiatives are in place. Scheme delivery is ongoing. 1c. Cost improvement efficiency pipeline engagement completed in September 2022. 2a. FGG occurring. 9 workstreams identified with SRO's. Plan on a page completed for each workstream. 3a. Training needs assessment now due to be delivered by end of October 2022. 3b. Future Focused Finance accreditation achieving Level 2: documentation to be submitted by end of December 2022, but confirmation may not be until end of March 2023. 4a. Oracle upgrade has been delayed until October 2022. 4b. FGG occurring. 9 workstreams identified with SRO's. Plan on a page completed for each workstream. 5a. Standard documentation for business cases in place and to be communicated (delayed from August 2022 due to comms strategy to be put in place). 6. Revision to due by date: now December 2022.			9

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 6: Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose			**Director of Finance**	Our service delivery	**SaTH is open to the HIGH risk appetite required to transform its digital services systems and infrastructure to support better outcomes and experience for our patients and the public.**			**Finance & Performance Assurance Committee**					
				Our governance									
Risk opened: previous risk within 2021/22			Helen Troalen										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Older buildings built with now outdated regulatory requirements • Restricted physical environment, unable to meet current capacity requirements • Backlog maintenance issues. • Fire safety risks • Over heating in some patient areas contributing to patient risk **Consequence:** • Poorer patient outcomes and patient safety issues • Regulatory or legal action taken against the Trust • Adverse publicity and reputational damage • Poor working conditions affecting staff health, experience and engagement - increased sickness absence and recruitment	4	5	20	• Board-approved fully funded Capital Programme including backlog maintenance plan and medical equipment budget in place eliminating all high risk backlog on a yearly basis. • Capacity & demand led major capital investment plan • Estates Plan ~~2015-2025~~ 2021-2026 in place. • Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure • Business continuity plan addresses overheating/heat wave and Estates actions to address overheating • Staff survey measures staff levels of engagement and morale (in relation to working environment)	**Reported to Board, committees and elsewhere:** • Capital plan developed and overseen by Capital Planning Group (CPG), chaired by Director of Finance (2nd) • Regular Estates report to Board (2nd) • Annual update backlog six facet survey that informs the capital plan (to be updated on a system wide basis from 2022/23 onwards) (1st) • Regular updates of fire action plans at Fire Safety Group (1st)	4	4	16	**Gaps in control:** 1. ~~Completing combined capital programme backlog survey system-wide/ICS.~~ *(No longer perceived to be a gap at quarter 2)* 2. Resources required to update and action Estates risks to ensure good risk management 3. Access for planned preventative maintenance (PPM) and backlog maintenance resulting in reduction in performance of the PPM and non-delivery of high risk backlog 4. Risk Management training for senior estates managers **Gaps in assurance:** 5. ~~System-wide capital programme backlog report~~ *(No longer perceived to be a gap at quarter 2)*	**Actions aligned to gaps:** 1. ~~Combined capital programme backlog survey to be completed by November 2022. Executive lead for SaTH: Director of Finance~~ 2. Seek external support in risk management - by December 2022 Associate Director Estates and Hospital Site Transformation. Executive lead: Director of Finance 3. Non-access will be addressed at trust Silver Control meeting by Head of Operational Estates and escalated to the COO at CPG ongoing. Executive lead: Director of Finance 4. Arrange risk management training by September 2022 via Associate Director Estates and Hospital Site Transformation. Executive lead: Director of Finance 5. ~~Report to be compiled following the backlog survey. Agreement required on where report will be received by October 2022. Executive lead: Director of Finance~~	1. ~~Survey commenced February 2022 and is now complete. Awaiting results of the survey (November)~~ 2. 3. Initial action complete and will remain ongoing. 4. Risk management training now identified as operating from 31st October to 2nd November 2022.			9

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 7a: Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.			**Director of Finance**	Our Service Delivery	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Finance & Performance Assurance Committee**					
				Our Governance									
Risk 7a was partly included within BAF risk 7 in 2021/22 and has been subsequently split out into risk 7a and 7b from 2022-23.			Helen Troalen										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest **Consequence:** • May lead to sub-optimal care, for example could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - e.g. ICO fines • Potential regulatory action - Network & Information System Regulations • Reputational damage and negative impact on public confidence • Temporary or permanent loss of data	5	5	25	• Cyber Security Manager in place • Senior Information Risk Owner (SIRO) in place • Trust actively contributing to cyber security management at Integrated Care System (ICS) level • Business continuity plans in place • Cyber security tools in place to support access management, security compliance, single sign-on • Security compliance in place to monitor security patch compliance and compliance with Data Security & Protection Toolkit (DSPT) • Information Governance (IG) strategy, policy and framework • Password and digital policies in place, with continual review • Network accounts checked and disabled after 90 days of inactivity if not used • CareCert updates reviewed for high severity alerts • Incident review processes and learning • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff	**Reported to Board, committees and elsewhere:** • Information Governance Committee - DSPT submissions June and Sept (2nd) • MIAA internal audit of cyber security in 2021 (3rd) • MIAA internal audit of Data Security Protection Toolkit (annual - June 2022 - Substantial assurance) (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Penetration testing report - NHS Digital/Dionach - 2021 (3rd) - report to Digital Services • Back-up review report - NHS Digital/MTI(3rd) - report to Board June/July 2021 • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services	5	3	15	**Gaps in control:** 1. Output of back-up remediation project behind schedule due to global shortage of microchips. 2. One vacant post within cyber security team. 3. Some devices will remain non-compliant with risk mitigation plans. 4. Active Directory issues from output of recent review. 5. Management of medical devices. 6. Skilled resource and availability within ICS outside of core hours. **Gaps in assurance:** 7. More regular oversight of cyber security required at IG Committee. 8. Penetration test report and remediation plan for 2022.	**Actions aligned to gaps:** 1. Technical architecture to be designed - by March 2023. Executive lead: Director of Finance 2. Recruit to vacant cyber security engineer post by October 2022. Executive Lead: Director of Finance 3. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions by March 2023. Executive lead: Director of Finance 4. Introduce privileged access management system (licences procured) by Sept 2022. Executive Lead: Director of Finance 5. Implement medical device discovery and security tool By March 2023. Funding to be confirmed (ICS level funding). 6. Trust to input into ICS level business case - part of 'levelling up' cyber strategy/capability - submission by September 2022. Executive Lead: Director of Finance 7. Monthly cyber security assurance report to be provided to IG committee by August 2022. Executive Lead: Director of Finance 8. Testing to be completed by July 2022. Remediation plan to be developed by end of August 2022, with implementation following. Executive Lead: Director of Finance	1. Hardware became available for installation in June 2022. Now configured and installed. Expected to be operational by the end of October 2022. 2. Appointed to position, but now have a further vacancy to recruit to. Recruitment progressing 3. Discussions started with divisional representation of affected systems 04/07/22, and remain ongoing . Financial implications under assessment. Continuing to work with divisions to implement mitigations and support business case development to replace systems where required. 4. Implementation complete September 2022. ~~due to begin 13/07/22~~. Project slipped due to availability of external resource. Expected to be complete by December 2022. 5. A system is on trial; costs obtained for Trust and ICS level. National announcement of capital cyber funding in September 2022 for one year, and case will be required for ongoing costs. 6. ~~Work has begun and is being refined.~~ All cases are under funding review to determine if they can be capital-only funded following national withdrawal of revenue funding. 7. Report at second draft internally within Digital Services. Ready to send once confirmation of dates is provided by the divisions. 8. Testing began 30th June 2022. Plan to present results at October's IGC.			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee						
BAF 7b: The inability to replace digital systems impacts upon the delivery of patient care			**Director of Finance**	Our Service Delivery	**SaTH is open to the HIGH risk appetite required to transform its digital services systems and infrastructure to support better outcomes and experience for our patients and the public.**			**Finance & Performance Assurance Committee**						
				Our Governance										
Risk 7b was partly included within BAF risk 7 in 2021/22 and has been subsequently split out into risk 7a and 7b from 2022-23.			Helen Troalen											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Lack of core project team resource - appropriate skillsets and experience • Lack of capacity and capability within Trust • Large scale business change programme alongside other competing business change programmes • Network replacement; Electronic Patient Record (EPR) replacement (move from SemaHelix to CareFlow PAS) along with a suite of software modules • Pharmacy and Medicines Administration (EPMA - electronic prescribing) system required - currently unfunded. • Order Communication system is past the end of its useful life - ~~funding sought to replace~~ • Replacement theatre system 'go live' in September 2022 • Second phase of maternity system required - neonatal system upgrade - funding sought for increase in scope • Risk to availability of supplier capacity due to number of trusts introducing patient administration systems **Consequence:** • Could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • Poor data quality - Order Communications System • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - misreporting • Potential regulatory action • Reputational damage and negative impact on public confidence • Potential negative impact on staff morale	4	5	20	• Digital Transformation governance structure in place - EPR Operational Readiness Group which feeds into Programme Board. EPR Programme Steering Committee which reports into Senior Leadership Team, reporting into Trust Board • Business continuity plans in place and to be implemented for new systems • Managed service for hosting of patient administration system • Working closely with procurement to secure recruitment into vacant posts • Standardised network infrastructure platform • Exploring lessons learned from elsewhere • Functional Design and Process Design Groups in place - meetings involving trust staff (for EPR Programme) • Digital Programme Team in place • Chief Clinical Information Officer/Clinical Safety Officer in place along with Clinical Safety Committee (safety of software and reducing hazards for patient safety) • Director of Digital Transformation/Lead in place - Trust and ICS • EPR Design Authority Group meet frequently to review the design and sign off to ensure fit for purpose • Capital funding awarded and business case developed for order communications and EPMA • Additional process improvement support identified following Bluespier theatre system implementation.	**Reported to Board, committees and elsewhere:** • Weekly reports against milestone progress from projects to EPR Programme Manager, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Steering Committee (2nd) • Monthly update into Senior Leadership Committee (2nd) • Digital updates to private Trust Board (2nd) • Report quarterly to NHS Digital and NHS Digital Programme Manager and Regional Digital Lead for Transformation sits on the Steering Group and receives monthly update (3rd) • Shropshire, Telford & Wrekin ICS Digital Lead reporting from 1st July 2022 • Getting To Good (G2G) digital transformation workstream milestones reported • Progress of the delivery of digital programmes across all partner programmes across the ICS is going to report into the Integrated Delivery Committee (3rd).	4	4	16	**Gaps in control:** 1. Requirements for Test Lead, Training Lead, Business Change Lead (currently unfilled positions) 2. Additional governance group required to assess operational readiness 3. Capacity within wider trust teams for implementations 4. EPMA, Order Communications and Neonatal implementations not yet funded - looking to a national funding solution for these requirements rather than internal. 5. Digital Strategy is currently in draft form **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Work with procurement temporarily to appoint into unfilled positions by August 2022. Executive lead: Director of Finance 2. EPR Operational Readiness Group to be established by July 2022. Executive lead: Director of Finance 3. Offering secondments into key roles to work with the digital programme by September 2022. Executive lead: Director of Finance 4. Business cases to be developed by September 2022. Business case funding will then be sought and the timeline will be dependent upon securing national funding. Executive lead: Director of Finance 5. Digital Strategy to be submitted to Trust Board August 2022. Executive lead: Director of Finance	1. Procurement framework selected and advertisement scheduled early July 2022. Procurement process exercise completed to identify the recruitment companies to access the required staff. Recruitment remains in progress via a difficult market place. Developing substantive staff with additional skill sets to increase the level of capacity and knowledge. Retention of staff remains fluid. 2. Fist meeting scheduled 19th July, with regular meetings ongoing. Action complete. 3. To be advertised in ~~July~~ October 2022. And also intend to bring in additional floor-walker staff to support operational readiness in October 2022. 4. Order Communications and EPMA business case written and due to go through internal governance in November 2022. Neonatal case in draft. 5. Digital strategy drafted and submitted and approved August private Board meeting. Scheduled for November public Board meeting.			9

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 8: The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.			**Director of Nursing**	Our patients and community	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Quality & Safety Assurance Committee**					
Risk opened: previous risk within 2021/22			Hayley Flavell										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' - 1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Poor processes, systems and culture • Operational challenges and pressures **Consequence:** • May lead to sub-optimal quality of care • Additional regulatory action • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties	4	5	20	• Getting To Good (G2G) workstream: Quality & Regulatory Compliance • Quality Strategy • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • External review, e.g. children's mental health action plan by SOAG • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Mock CQC inspections internally with input from external stakeholders • Palliative and End of Life Steering Group • Quality Matrons • Quality Spot checks internal audit review • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Patient Safety Specialist in post • Genba visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • Planned maternity CQC inspection in 2022 • Current regional Insight visit for first Ockenden Report which focused on immediate and essential actions.	**Reported to Board, committees and elsewhere:** • Quality & Safety Assurance Committee (QSAC) reports received (monthly) and monthly report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions, to CLS-O, QSAC (2nd) • RALIG and NIQAM meetings (1st) • Rapid Review process reporting (1st) • Patient Experience Group (1st) • Mortality Group (1st) • Deteriorating Patient Group (1st) • Infection Prevention and Control Committee (1st) • Safeguarding Assurance Committee (2nd) • Bi-weekly informal meetings with CQC - chaired by Director of Nursing (2nd) • Quarterly engagement meetings with CQC (3rd) • CQC action plan owned by Divisions and confirm and challenge in place (1st) • System Oversight Group - chaired by the Region and CQC attend (3rd) • External audit were satisfied in their Value For Money opinion that no significant weaknesses remain in 2021/22 relating to maternity services (3rd).	4	4	16	**Gaps in control:** 1. Lack of whole system support for healthcare services (e.g. children and young peoples mental health and Urgent and Emergency Care - UEC). 2. Lack of capacity/capability to develop the building of the IT (InPhase) structure on time for CQC self-assessment tool. 3. Amber RAG rating in infection, prevention and control (IPC) from NHSI/E in July 2022. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. System leadership required 2. Deliver a collaborative approach from performance, quality and PMO functions for the Inphase system development. Timescale for development TBC following meeting to be held on 21/10/22. Executive Lead: Director of Nursing. 3. The IPC action plan which is in place is to be delivered by November 2022. Executive Lead: Director of Nursing	1. The Trust is working with the ICS. 2. CQC self-assessments are still being undertaken (palliative and end of life, children and young people and outpatients undertaken so far as part of the programme), but not operating as efficiently as it could be with an InPhase system. 3. Action plan developed and in place, and being delivered, with a planned re-inspection in December 2022.			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 9: The Trust is unable to recover services post-covid to meet the needs of the community / service users			**Interim Chief Operating Officer**	Service Delivery	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**FPAC (financial impacts) and QSAC (patient/ quality/ safety related)**					
				Our patients and community									
Risk opened: previous risk within 2021/22			Sara Biffen	Our partners									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Delayed treatment times and backlog due to the Covid-19 pandemic • Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres • Bed capacity and urgent care demand • Insufficient capacity to meet demand **Consequence:** • May lead to sub-optimal care • May lead to harm due to the unmet need • Financial activity impact • Regulatory action • Damage to reputation and negative impact on public confidence.	**4**	**5**	**20**	Performance controls below (refer to BAF 3 and 4 for workforce controls): • Getting To Good (G2G) Theatre Productivity workstream • ICS Planned Care Programme / Plan • Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand, and SaTH Internal Recovery Group • Departmental and Divisional monitoring of RTT, imaging and endoscopy • NHSE/I Diagnostic Task Group • NHSE/I weekly assurance meetings for cancer and RTT • Monthly Performance Review Meetings • Enhanced operational management structure with focus on elective and urgent care • Weekly validation process in place	**Reported to Board, committees and elsewhere:** • G2G progress reviewed - reported to Board (2nd) • Performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Weekly Trust Cancer performance meetings (1st) • Cancer Assurance Committee (2nd) • Standing monthly IPR reports to Quality & Safety Assurance Committee and Finance & Performance Assurance Committee (2nd) • Monthly reporting to Senior Leadership Committee-Operational / Performance Review Meetings (2nd) • Shropshire Telford & Wrekin (STW) Planned Care Operational Board reporting monthly (3rd) • Elective Recovery Board - Midland NHSE/I (3rd) • Weekly call - 104 and 62 day weekly cancer call with NHSE and STW (3rd) • Cancer trajectories - 62 day backlog, and 28 day faster diagnosis • RTT - 104 and 78 week recovery trajectory • DMO1 (diagnostics)recovery trajectory to FPAC (2nd)	**4**	**5**	**20**	**Gaps in control:** 1. Lack of workforce capacity in radiology to meet clinical demands for recovery of services post Covid-19 pandemic 2. Shortage of theatre staff on both sites to meet capacity requirements 3. Inadequate bed stock to maintain inpatient green zones on both sites 4. Insufficient outpatient booking/scheduling staff **Gaps in assurance:** 5. Refinement of Integrated Performance Report	**Actions aligned to gaps:** 1. Radiology workforce plan in place - undertaking recruitment including international recruitment; recruiting to support roles; continuing to develop the radiology workforce, using apprenticeships. First cohort of apprenticeship qualifies June 2023. Executive lead: Chief Operating Officer 2. Workforce plan in place to be delivered by March 2023. Executive lead: Chief Operating Officer 3. Elective hub from April 2023 at PRH (phase 1 approved and awaiting approval from NHSE of phase 2 - due 27 September 2022- part of Transformation Investment Fund). Ongoing works for move of renal outpatient dialysis from PRH to Hollinswood House - expected March 2023. Executive lead: Chief Operating Officer 4. Develop and recruit to apprenticeship positions by October 2022. Use temporary bank staff along with inpatient booking staff to cover vacancies in the interim. Executive lead: Chief Operating Officer 5. Review current report with a view to making it more concise by December 2022. Executive lead: Chief Operating Officer	1. Training completed in July and August 2022 to increase the capacity of the POD (the new Radiology unit at RSH). 2. 3. Extra modular ward was due to be operational from start of August 2022 and now utilised for Critical Care on a temporary basis. 4. 5. Work ongoing. Discussed at Executive Team Meeting w/c 19 September 2022 and agreed format.			**3**

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 10: The Trust is unable to meet the required national urgent and emergency standards.			**Interim Chief Operating Officer**	Service Delivery	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**FPAC (financial impacts) and QSAC (patient/ quality/ safety related)**					
				Our patients and community									
Risk opened: previous risk within 2021/22			Sara Biffen	Our partners									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • lack of capacity and workforce. • Increase in complexity of demand • Staff becoming progressively more tired with each increase in Covid attendances / admissions, leading to more staff sickness • Community capacity for pathways 0, 1, 2 and 3 insufficient to meet current needs for timely discharge • Primary and community health and care capacity not meeting pre-hospital and discharge demand **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Urgent work impacting on elective capacity • May lead to sub-optimal care and poor patient experience • Regulatory action • negative impact on reputation and public confidence. • Impact on ambulance handover delays and subsequent impact on ambulance availability within the community	**4**	**5**	**20**	• Getting To Good (G2G) Urgent & Emergency Care (UEC)programme. • Work on System, Urgent and Emergency Care Plan • ICS UEC Board supported by UEC Operational Group • Capacity and demand analysis ~~linked to funding~~ • Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care) • Local Care Programme (LCP) - The system will build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities. The aim of the LCP is to avoid continued growth in acute UEC demand and capacity.	**Reported to Board, committees and elsewhere:** • Finance & Performance Assurance Committee (monthly) (2nd) • Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) • Emergency Department Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Silver' and 'Gold' system meetings, as triggered by escalation levels (2nd) • Integrated Care System (ICS) UEC Operational Group - fortnightly (1st) • ICS UEC Board - monthly (2nd) • Safety Oversight and Assurance Group - monthly (co-chaired by NHSI and the ICS and members include CQC, HEE, GMC, NMC, Healthwatch) (3rd) • Monthly reporting to the CQC in relation to compliance against the remaining Section 31 conditions, including initial assessment within 15 minutes for all patients (including paediatrics) (3rd). • Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd).	**4**	**5**	**20**	**Gaps in control:** 1. Workforce challenges, including consultants, nurses, HCA's and middle tier colleagues 2. Estate constraints ~~in RSH Emergency Department (adults and paediatrics) and~~ at PRH Emergency Department (paediatrics) 3. Inpatient and assessment unit capacity to meet medical and surgical demand 4. Capacity is not expected to meet demand without significant escalation and impact upon performance 5. Winter schemes to mitigate the rise in demand for UEC 6. Reconfiguration of some services for better healthcare management **Gaps in assurance:** 7. Reported to QSAC, but not all mitigations are addressing key actions	**Actions aligned to gaps:** 1. Appointment of substantive workforce in specific departments and staff groups, e.g. ED, medical and nursing staff, therapy staff, pharmacy staff and co-ordination with wider trust-wide recruitment schemes, e.g. RN and HCA recruitment and opportunities for international recruitment, by March 2023. Executive lead: Chief Operating Officer 2. RSH ED works programme - complete July 2022. A business case for the PRH ED (paeds) in development. 3a. Acute floor project at RSH - case reviewed at SLC, IIC (investment and innovation committee) and ICS investment committee - to be tabled at ICS UEC Board in July 2022. 3b. Plus creation of acute ward at PRH due to the move off site of renal dialysis - due March 2023. 4. Delivery of acute flow improvement programme - by December 2022. Supported by executive led assurance group. 5. Develop integrated system winter plan by beginning of September 2022 6. (see 3a and 3b plus SaTH involvement in the ICS local care programme, e.g. virtual ward - see BAF risk 12) 7. Continued reporting to QSAC and CQC, with triangulation of data and continued monitoring - throughout 2022/23	1. 2. RSH ED works programme completed August 2022. 3a. Case approved and estates work underway to create acute floor. 3b. Underway 4. As per 3a 5. Plan produced; submitting SaTH Winter Plan to Trust Board in October 2022.			**3**

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 11: The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increased risk to the quality and continuity of services.			**Director of Strategy & Partnerships**	Service Delivery Our patients and community	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Finance & Performance Assurance Committee**					
Risk opened: 1 April 2022			Nigel Lee										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • Emergency Department and multiple services (e.g. emergency surgery, critical care, acute medicine) operating at two sites (Princess Royal Hospital and Royal Shrewsbury Hospital) • Development of the (capital) scheme was temporarily paused from February 2020 due to the impact of COVID-19 • Continued challenge in achieving national access performance standards • Insufficient shift to local services outside of the acute hospital setting - requirement to offset additional growth of 151 acute beds **Consequence:** • Unsustainable infrastructure • Unsustainable clinical services • Reduced patient satisfaction • Potential impact on quality and safety of patient care • Impacts financial sustainability and backlog maintenance not reduced • Reduced staff morale • Less efficient estate • Not achieving national access performance standards • Workforce position unsustainable if continue to duplicate services across two sites	5	4	20	• Hospital Transformation Programme (HTP) - to produce the outline business case (OBC) developed by SaTH to further develop the options, on behalf of the local health system/Integrated Care System (ICS) • Work on the System, Urgent and Emergency Care (UEC) Plan - led by ICS UEC Board supported by UEC Operational Group • Reviewing options for accelerating any pathway development in HTP, e.g. (1) elective surgical hub at PRH; (2) critical care model; (3) support to the ICS local care programme for community based pathways; (4) mutual aid and independent sector options for elective care. • Development of the integrated ICS Workforce Plan.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly) (2nd) • Shropshire Telford & Wrekin ICS Integrated Delivery Board (monthly) (2nd) • HTP Programme Board (monthly) with ICS members (2nd) • Finance & Performance Assurance Committee (monthly) (2nd) • UEC plan to ICS UEC Board - monthly (2nd) • Hospital Transformation Programme Committee (SaTH internal, including non-executive), monthly (2nd)	4	4	16	**Gaps in control:** 1. ~~Strategic Outline Case (SOC) not yet approved (due to be considered by National Joint Investment Committee on 29 July 2022)~~, Following approval of the Strategic Outline Case (SOC), ~~which~~ the outline business case will require to be developed. 2. Elective surgery hub (first scheme) short form business case submitted to NHSI in June 2022. ~~Awaiting feedback.~~ **Gaps in assurance:** 3. Personnel and governance to be expanded once move to outline business case stage.	**Actions aligned to gaps:** 1. ~~Once SOC reviewed by National Joint Investment Committee at 29 July 2022 and approval to proceed is received, then~~ Develop the outline business case (OBC) and submit to NHSI by mid-April 2023. Executive lead: Director of Strategy & Partnerships. 2. Await feedback from submission of second elective surgery hub scheme business case ~~in late July~~ at end of September 2022. Executive lead: Director of Strategy & Partnerships. 3. ~~Proposed governance structure and leadership and programme personnel requirements have been mapped. The outcome of the decision of the National Joint Investment Committee on 29 July 2022 to progression, after which recruitment and drawing down funding will progress (date awaited)~~. Continue recruitment process now that funding is confirmed, although still awaiting formal draw down confirmation.	1. SaTH received approval of the Strategic Outline Case and support to move to the OBC stage on 26 August 2022. Development of the OBC is underway. 2. SaTH received formal confirmation on 22 August 2022 from the National Elective Recovery Targeted Investment Fund Team that the first scheme at Princess Royal Hospital was approved (with conditions). The second scheme of the Elective Surgical Hub at PRH is being considered at the national panel meeting on 27 September 2022. 3. Approval of SOC received. Request for drawdown of capital funding submitted mid-August 2022. Awaiting final NHSE confirmation of funding. Appointment of key partners such as strategic partner and healthcare planner has been completed following formal tender process. Recruitment to key roles in HTP team in progress. (Note: The Hospital Transformation Programme (HTP) OBC will have significant dependencies with the Integrated Care Partnership Strategy and the ICS Joint Forward Plan. Both ICP Strategy and ICS Joint Forward Plan are planned for production alongside the development of the HTP OBC).			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 12: There is a risk of non-delivery of integrated pathways, led by the ICS and ICP.			**Chief Operating Officer (note: Shropshire Community Trust are organisational lead for this ICS programme, SaTH are key members)**	Service Delivery	**SATH has a SIGNIFICANT risk appetite for collaboration and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve.**			**Quality & Safety Assurance Committee**					
				Our patients and community									
Risk opened: 1 April 2022			Sara Biffen	Our partners									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • lack of integrated model of service delivery locally • High non elective admissions • A shift required from acute to community setting for models of care • Challenges in the recruitment of key practitioner roles across health and care to the rapid response service in the Shropshire area • Lack of health prevention and early interventions • Insufficient current workforce capacity in clinical and corporate teams across the system to deliver new ways of working • Availability of systemwide digital specialist resource to implement effective remote monitoring, and enable timely sharing of robust data, and associated impact of achieving agreed trajectories for virtual ward mobilisation **Consequence:** • Increased length of acute inpatient stay • Lack of bed capacity in acute setting impacting on patient flow and reduced delivery of elective activity • May reduce quality of patient care including risk due to ambulance handover delays • Increased demand for emergency department services and non-elective admissions to hospital • Lack of innovation and continuous improvement of services • Reduced staff experience and morale • Increased ambulance conveyances from one care setting to another • Increased emergency community nursing referrals.	4	4	16	• Shropshire, Telford & Wrekin ICS Local Care Transformation Programme in place • Alternative to Hospital Admission (A2HA) business case developed which was approved by the Investment Panel in the summer of 2021 and approves the implementation of county wide rapid response, county wide advanced care planning in care homes, county wide respiratory in/outreach service. • Five year programme plan in place • Programme management in place with fortnightly PMO meetings- programme reported through ICS digital system (Inphase) • 'Deep dive' into each workstream on a regular basis • ICS Medical Director plan for group of speciality/condition based pathway improvements, e.g. respiratory, diabetes, cardiology, musculo-skeletal therapy (MSK).	**Reported to Board, committees and elsewhere:** • Reports to Shropshire Telford & Wrekin ICS Integrated Care Delivery Board (monthly) (2nd) • Report to place-based partnership Boards Shropshire Integrated Partnership Committee (SHIP) and Telford and Wrekin Integrated Partnership Committee (TWIP) (2nd) • Local Care Transformation Programme Oversight Group - monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Board - monthly (2nd)	4	4	16	**Gaps in control:** 1. Limited detail and limited delivery of the changes in improvement, as a relatively new programme 2. System agreement to the services "as is " services in and out of scope of the programme. 3. Reliance on physical acute beds rather than some 'virtual ward' capacity **Gaps in assurance:** 4. Robust population health data intelligence	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Local Care Programme - ongoing. Lead Executive: Chief Operating Officer and Medical Director 2. *Not a SaTH action to lead* 3. Change clinical pathways and culture to use virtual wards - the scheme aims to open 249 beds by the end of December 2023 (net benefit 156 beds due to longer LOS in virtual ward). ~~Executive: Medical Director.~~ Lead: Shropshire Community NHS Trust 4. *Not a SaTH action to lead*	1. 2. 3. This is now moving to a system approach led by Shropshire Community NHS Trust working with SaTH clinicians including the Clinical Director for acute medicine. 4.			9

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 13: Trust-wide services and / or resources may be further affected following the publication of the final Ockenden Report.			**Director of Nursing/ Director of Governance & Communicat-ions**	Our People	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Quality & Safety Assurance Committee**					
				Our patients and community									
Risk opened: 1 April 2022			Hayley Flavell Anna Milanec	Service Delivery									

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Target total risk score
Cause: • First Ockenden (maternity)review report (10th December 2020) • Final Ockenden review report (30th March 2022) • National media coverage **Consequence:** • Use of resources to address the resulting impacts, following the final report • Negative impact on Trust reputation • Lack of public confidence • Potential impact on year-end audit opinion • Increase in maternity Freedom of Information requests • Increased letters and questions to Board • Increased legal fees	4	5	20	• Getting To Good (G2G) Maternity Transformation workstream • Maternity Transformation Programme • Ockenden Report Assurance Committee established March 2021 • Maternity framework and leadership framework which covers Ockenden action plan • Maternity Board Champions in place • Freedom to Speak Up Guardian • Dedicated communications support - maternity based • Staff welfare support - Trust-wide, with enhanced for maternity • Healthwatch enter and view visits • Maternity Voice Partners - 15 steps • PACE panel for patient experience	**Reported to Board, committees and elsewhere:** • Quality & Safety Assurance Committee (monthly) (2nd) • Ockenden report action plan to Board (2nd) • 'Triple A' (alert, assurance, advise) report into Board from chair of Ockenden Report Assurance Committee (ORAC) (monthly) (2nd) • Board champion's report into private Board (monthly) (2nd) • CNST, maternity metrics and exception reports within Integrated Performance Report to Board (monthly) (2nd) • Freedom to Speak Up Guardian Report to Board quarterly (2nd)	4	4	16	**Gaps in control:** 1. Resources required to complete all the local and national recommendations arising from the Ockenden report 2. Managing the legacy impact of the review **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Continually review resources in place to address the Ockenden recommendations - each quarter. Executive lead: Director of Nursing 2. Trust to be sensitive and open to stakeholder and community views and concerns regarding maternity services, e.g. expectant mothers visiting maternity unit - each month, by March 2023. Executive lead: Director of Governance & Communications	1. Continual review until all Ockenden actions complete. Freedom of Information (FOI) manager in place to deal with increase in FOI requests. Progress being made against Ockenden recommendations and tracked at Board and ORAC. 2. Trust continues to work with stakeholders and community members regarding access to maternity services.			3