The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
9 February 2023

Agenda item	016/23			
Report Title	**Board Assurance Framework – Draft Quarter 3 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:	Finance & Performance Assurance Committee (FPAC) – 24 January 2023 Quality & Safety Assurance Committee (QSAC) – 25 January 2023 Audit and Risk Assurance Committee (ARAC) – 1 February 2023			
Executive summary:	The Board Assurance Framework (BAF) content has been refreshed for Quarter 3, 2022/23 by the executive risk owners. This includes updates to progress with the actions associated with gaps in control and assurance. **Recommendation(s):** The Board is asked to review the content of the draft quarter 3 BAF and: a) Consider if the content reflects the strategic risks within the organisation and if the risk scores are appropriate? b) Consider if there is evidence of successful management of the risks and if actions are being progressed in a timely manner? c) Consider if FPAC should continue to oversee BAF risk 11 or if there is merit in direct Board oversight of this risk? d) Agree the quarter 3 BAF, including the overseeing committee change for BAF risk 7a from FPAC to ARAC and the reduction in the current risk score of BAF risk 13 (from 16 to 6).			
Appendices	**Appendix 1**: Draft Board Assurance Framework - Quarter 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 3 BAF content was undertaken during December 2022 and in early January 2023, following the quarter 2 BAF content which was agreed by Board on 08 December 2022.

2.0 Significant changes to the BAF in quarter 3 2022/23

2.1 The BAF narrative with regards to progress of actions associated with gaps in control and assurance has been significantly refreshed in quarter 3. Additional narrative is shown in blue text within the draft BAF in **Appendix 1,** including some relevant proposed updated (extended) action timescales.

2.2 The current risk score of BAF risk 13 (*Trust-wide services / resources may be further affected by the publicity and negative media attention following publication of the final Ockenden Report*), which is overseen by Quality & Safety Assurance Committee (QSAC), is proposed to be reduced from 4x4=16 to 3x2=6. This proposed reduction in risk score is due to the resource requirements following publication of the Ockenden report now being less likely.

2.3 There are no other changes proposed to risk scores in quarter 3 by the executive risk owners.

2.4 One additional action, action 3b (aligned with a gap in control), has been added within BAF risk 2 and one additional action, action 9, has been added with BAF risk 4.

2.5 A number of actions indicate positive progress and are shown as complete within BAF risks 5, 6 and 7b in quarter 3 (risks overseen by FPAC).

2.6 It is proposed to change the overseeing committee from FPAC to Audit and Risk Assurance Committee (ARAC) for BAF risk 7a (*Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation*), as cyber risk falls within ARAC terms of reference.

3.0 Feedback received on the draft BAF

3.1 There has been further discussion in quarter 3 by QSAC with regard to the overlaps within BAF risks 1 and 2. It is planned to make proposals to QSAC, and subsequently Board, in quarter 1 2023-24 with regard to a potential future merged risk.

3.2 A point was raised at the FPAC meeting, with further discussion of this at ARAC on 1 February regarding BAF risk 11 and where the oversight of this risk should best reside. There was some discussion as to whether this risk should be overseen directly by the Board due to its strategic nature and that relevant significant business cases would be agreed by the Board. There was also a view held that the deploying of resources would link with FPAC oversight. It was agreed to further discuss this outside of the ARAC meeting and to seek the Board's view as to the appropriate overseeing committee/Board for BAF risk 11 moving forwards.

4.0 Risks, actions and the Organisation's Top risks

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

4.2 Based on the draft current total risk scores for the quarter 3 BAF in 2022-23, there are four top risks with a current total risk score of 20; eight risks with a current total risk score of 16; one with a score of 15 and one with a score of 6, as indicated within the BAF summary page. The four top risk scores, all with a current total risk score of 20 are shown below:

The top four BAF risks based on current draft total risk scores at quarter 3:

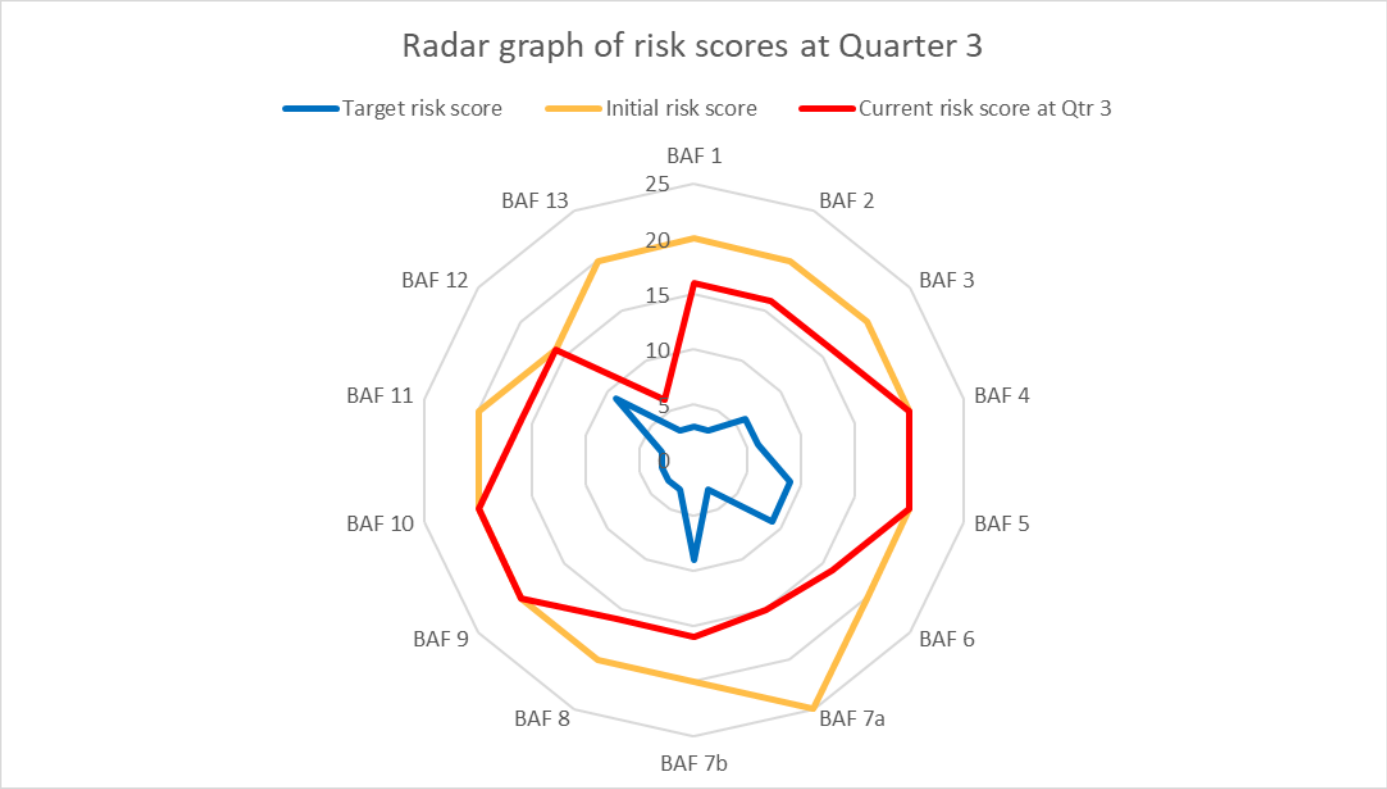
No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 3, 2022-23	Change since quarter 2
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Board	5x4 = 20	No change ↔
BAF 5	The Trust does not operate within its 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 ↔

4.3 Being aware of the proposed top scoring risks (based on the current risk score) should assist the 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.

5.0 Visual representation of risk scores

5.1 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 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 and achievable.



6.0 Recommendation(s)

The Board is asked to review the content of the draft quarter 3 BAF and:

a) Consider if the content reflects the strategic risks within the organisation and if the risk scores are appropriate?

b) Consider if there is evidence of successful management of the risks and if actions are being progressed in a timely manner?

c) Consider if FPAC should continue to oversee BAF risk 11 or if there is merit in direct Board oversight of this risk?

d) Agree the quarter 3 BAF, including the overseeing committee change for BAF risk 7a from FPAC to ARAC and the reduction in the current risk score of BAF risk 13 (from 16 to 6).

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework 2022/23 - draft quarter 3 (October to December 2022)

(Updated December 2022 - January 2023 (Version 1.1))

The Shrewsbury and Telford Hospital NHS Trust

							Current risk score				
Board Assurance Framework 2022/23 - Summary at Quarter 3 (October to December)		**Alignment to strategic goal(s)**	**Initial (inherent) risk score**	**Target risk score**	**Lead Executive**	**Lead Committee**	**Quarter 4 (2021-22)**	**Quarter 1 (2022-23)**	**Quarter 2 (2022-23)**	**Quarter 3 (2022-23)**	**Change in current risk score between Q2 and Q3 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	4x5 = 20	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	**Audit and Risk Assurance Committee**	4x4 = 16	5x3 = 15	5x3 = 15	5x3 = 15	No change ↔. Note: Change in lead committee from FPAC to ARAC.

Board Assurance Framework 2022/23 - Summary at Quarter 3 (October to December)		Alignment to strategic goal(s)	Initial (inherent) risk score	Target risk score	Lead Executive	Lead Committee	Current risk score				Change in current risk score between Q2 and Q3 and further comments
							Quarter 4 (2021-22)	Quarter 1 (2022-23)	Quarter 2 (2022-23)	Quarter 3 (2022-23)	
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	4x5 = 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	5x4 = 20	4x5 = 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	4x4 = 16	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	4x3=12	4x4 = 16	4x4 = 16	No change ↔
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	4x4 = 16	4x4 = 16	3x2 = 6	↓ Reduction in current risk score as the resource requirements following publication of the Ockenden report are now less likely.

The Shrewsbury and Telford Hospital NHS Trust

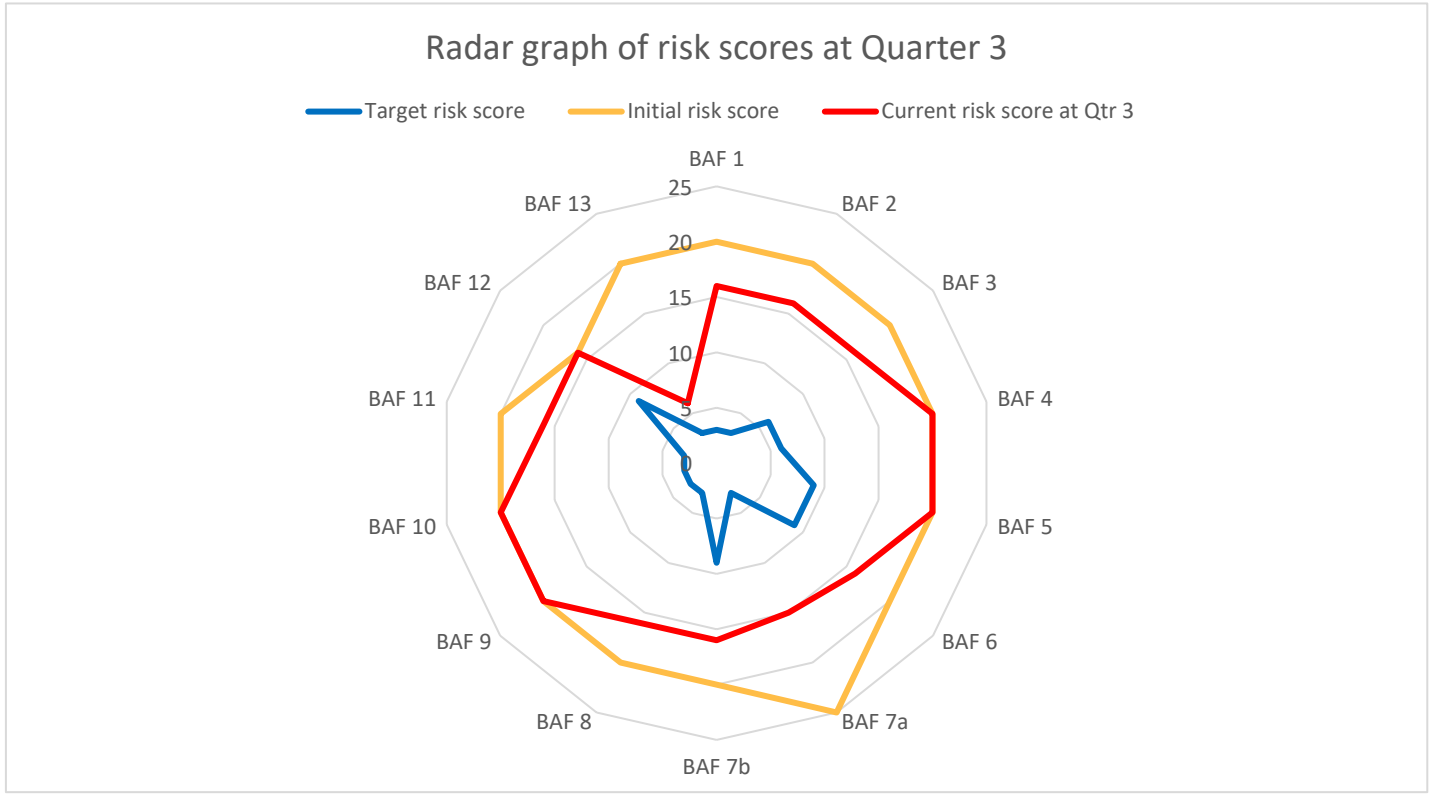
Risk scoring framework

	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

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	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 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 • Rapid handover by ambulance service • Strike action **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 • Rapid handover could result in a greater volume of patients in ED than can be received and cared for	5	4	20	• Getting To Good (G2G) workstreams: Levelling up Clinical Standards and Fundamentals in Care. • Quality Strategy and Corporate 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:** 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 initiation of emergency department transformation programme which includes clinical pathways - by 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. Agreement at Board to proceed with agency use of consultant workforce (Q3). 2a. Initial ward moves have been completed to allow estates work to commence. Date extended to December 2022 (from October). Acute medical floor opened December 2022. Further recruitment and internal building work to make fully operational required Q4. 2b. Work ongoing. 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. Bluespier theatre system operational in Q3. 4. Request to extend deadlines for some actions into 2023 made at October ARAC meeting. Incident reporting Board report continues to be developed and new style currently under trial for maternity incidents. 5. Robust training programme in place for pre-and post-registration nurses. Also Allied Healthcare professionals educational lead in place. Internal CPD programme introduced for senior doctors Q3. New Director of Medical Education being appointed Q4 to oversee both undergraduate and post-graduate medical education and provide input into quarterly workforce report to Board. 6. Plans to appoint Associate Medical Director whose portfolio will include reviewing governance of clinical guidelines in Q4. 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										
Risk opened: previous risk within 2021/22			Hayley Flavell/ John Jones	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:** • Increased harm • Inconsistencies in governance arrangements • Poor patient experience • Increased complaints • Poor reputational damage • Lack of confidence in the organisation • Not an open and honest culture • 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 and Corporate 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 (via audit programme of fundamentals in care) • 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) • CQC action plan owned by Divisions	**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) • Monthly Nursing Metric meetings, Quality Operational Meeting (1st) • Divisional Performance Review Meetings (2nd) • 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). • ICB assurance visits - paediatric visit, safeguarding and ED visit regarding ambulance offload delays 2022 (3rd) • Performance Management Review Meetings with Divisions, executive led (2nd)	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 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~~ 31st March 2023. Executive Lead: Director of Nursing. 3a. 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. 3b. Introduce quarterly report on progress of serious incident completed actions and overdue actions, including how the Division are monitoring learning from incidents to be included in the Divisional Governance Reports and triple AAA report to QOC. By 31 March 2023. 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 June 2023 ~~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. The new process is embedding. 2. Draft Process has been developed for agreement by CEO/DON - ongoing. 3a. Completed (Q1) - All Serious Incident actions are now uploaded to the Datix Incident Management system which enables the teams to monitor and report on actions completed and overdue. Overdue actions are tracked through the Divisional Governance teams and also monitored through the monthly Serious Incident Review Group (SIRG) with the Quality leads for the ICS 3b. Time to be dedicated in the New Year to discuss and agree serious incident reporting with the Divisional leadership team. 4. The Complaints Team is being managed by the Quality Governance Team and aligned with the Divisions in relation to support since Sept 2022. Arrangements ~~have just begun, but are in their infancy~~ are in place. 5. This is ongoing with reporting on progress through the Steering Groups and ODG (Operational Delivery Group). 6a. Phase 1 of the development has been presented to the executive team, which includes high level data that is currently held or reported within the Trust. The next step is to ensure that any missing data is aligned to the Quality Strategy. Phase 2 is about to commence (Jan 2023), to incorporate all required metrics and data for metrics not currently reported on. Phase 2 is planned for completion by March 2023, with final phases then due to commence for interconnections of metrics and the final build/deployment, scheduled for June 2023. 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 2020 (2nd) • Equality, Diversity & Inclusion Strategy approved by Board 2020 (2nd) • Recruitment & Retention Strategy progress approved/received by the Board 2020 (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, with continuous review.	1. Formally launched for new managers in November 2022 as part of Trust Recognition Week. To be reviewed before rolling-out to existing managers from April 23. 2a. Internal audit completed. b. Workshops are underway with key specialities and departments to review their staffing models and capture workforce requirements. Review of workforce planning within SaTH and across the ICS undertaken - report completed September 2022. 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 completed and rolled out October 2022. Work underway to modernise agile working, including a supporting policy. 4. Work in progress and on track. 5. Agreement to develop one People Plan across the ICS. Work will commence January 2023. 6. Now have annual recognition plan in place. Review of benefits work is ongoing. Trust Recognition and celebratory awards successfully delivered in November 2022. Project plan for 2023 to commence in the New Year. 7. Ongoing. Talent Strategy currently being drafted - to be taken to OPG in quarter 4. 8a. HTP support ongoing and ICS workforce transformation group in place. HTP Business Partner commenced in post 12/12/22. 8b. Commenced review of health and wellbeing framework diagnostic tool - on track. 8c. Lead consultant joined trust 1 September. Recruitment to the team has been completed. Scoping current services and design of future services. Psychological services contract extended until end of December 2022. Formal launch of the new staff psychology hub service being planned for March 2023. 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: • 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 (OPG), 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) • Engagement conversations reported to Education Group November 2022 (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 9. Full implementation and alignment of the Learning Management System (LMS). **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 9. Targeted interventions to support mandatory training (target 90%).	1. Reviewed use of ESR as a platform to capture exit interview data. ESR exit questionnaire implemented October 2022 and live for staff to access. Reviewing process and existing avenues to capture staff thoughts for a robust exit interview system. 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 rolled out October 2022. Work underway to modernise agile working, including a supporting policy. 4. Reporting and action completed September 2022. 5a. Ongoing. Talent Strategy currently being drafted to be taken to OPG in quarter 4. 5b. Formally launched for new managers in November 2022 as part of Trust Recognition Week. To be reviewed before rolling-out to existing managers from April 23. 5c. On track - procurement exercise to commence in quarter 4. 6. Discussed with Medical Director and at Education Group. Business case is under preparation. Funding source has been agreed for Head of Medical Education post which is out to advert December 2022. 7. On track. Organisational strategy approved by Board December 2022. Planning underway to link with values and behaviours work quarter 4 and quarter 1. 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 2022). Annual equality reports and gender pay reports due to be submitted to Board March 2023. 9. Consistent improvement in mandatory training compliance since April 2022. Current compliance at 88.73% at 08 December 2022.			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. Agree 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~~ March 2023. Executive lead: Director of Finance. 7b. Review of budget surgery agendas and actions log by end January 2023. Executive lead: Director of Finance. 7c. Robust methodology for benchmarking of budgets by June 2023 against widely available peer data to inform future budget setting and the efficiency pipeline ~~by Mach 2023~~. Executive lead: Director of Finance.	1a. Process embedded. Action complete Q3. 1b. Trust wide initiatives are in place. Scheme delivery is ongoing. 1c. Cost improvement efficiency pipeline engagement completed in September 2022. Engagement on 2023-24 plan is ongoing. 2a. FGG occurring. 9 workstreams identified with SRO's. Plan on a page completed for each workstream. Action complete Q3. 2b. Audit completed with three recommendations and associated action plan which will continue into 2023-24. 3a. Training needs assessment completed quarter 3. Action complete. 3b. Future Focused Finance accreditation achieving Level 2: documentation submitted December 2022, but confirmation may not be until end of March 2023. 4a. Oracle upgrade was completed October 2022. Action complete Q3. 4b. FGG occurring and embedded. 9 workstreams identified with SRO's. Plan on a page completed for each workstream. Action complete Q3. 5a. Standard documentation for business cases in place and has been communicated. Action complete Q3. 5b. Draft five year plan in place. Work on-track at Q3. 6. Due by date revised to December 2022 in Q2. Draft five year plan in place. Work on-track at Q3. 7a. Upgrade delayed and working with external reviewer in Q4. Target date to be extended to March 2023. 7b. Work on-track. 7c. Target date extended to June 2023 to reflect phases of work involved in the process.			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 - backlog maintenance programme elongated by the Covid-19 pandemic. • 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 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. Action complete Q3. External support sought; all band 6 and above Estates staff have received risk management training. 3. Initial action complete and remains ongoing. Escalation continues to Capital Planning Group where access to areas is not available, e.g. to address air handling units. Also raised at Infection Prevention Control Assurance Group. 4. Action complete Q3. Risk management training operated 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.**			**Audit and Risk 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~~ February 2023. 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~~ January 2023. 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. Configured and installed and operational end of October 2022. "Immutable", cross-site backups are now live. Critical data to be sent to cloud based storage due to be completed ahead of March 2023 deadline. 2. Appointed to position, but now have a further vacancy to recruit to. Recruitment progressing. Original position was appointed to, however candidate declined and recruitment process restarted (hence change in target date in Quarter 3). All vacant posts have now been recruited to and new staff will be in place by 20 February 2023. Action complete. 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. Progress is tracked by NHS Digital and reported back on a monthly basis. Achievement of target date to be reviewed in Quarter 4 as risk that March 2023 might not be achieved due to resource requirements. 4. Implementation complete September 2022. Solution now live and 3rd parties are being migrated as a business as usual activity. 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. Confirmation of capital funding received. Currently reviewing commercial offering from the supplier. 6. 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. IG Committee cancelled in October and rearranged for January 2023. 8. Action complete. Testing began 30th June 2022 and was completed early July. Remediation plans developed. Plan to present results to IGC in January 2023.			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~~ February 2023. 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. Action now complete Q3. Test, Training and Business Change Leads appointed. 2. Fist meeting scheduled 19th July 2022, with regular meetings ongoing. Action complete (Quarter 2). 3. Action now complete at Q3. Ward Clerk post start date January 2023, Medical Secretary post start date February 2023. Floor-walker resource appointed. 4. Summary of business cases and draft funding bids submitted to FPAC Dec 22 due to change in national funding application process. Neonatal case seeking additional funding via Capital Programme due to scope increase. Confirmation of funding expected before 27th January 2023. 5. Digital strategy submitted and approved August 2022 private Board meeting and November 2022 public Board meeting. Action complete Q3.			**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) • CQC self-assessment mock visit and executive level table-top sign off for core services (2nd) • 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). • NHSE IPC inspection review undertaken 12 December 2022 and rated 'green' (3rd) • MIAA (internal audit) Ockenden first report progress review, November 2022, providing *Substantial* assurance (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 NHSE 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~~ March 2023. 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. A Midland Partnership Foundation Trust and SaTH meeting is planned for new ways of working for children and young people with mental health. 2. Several internal and external meetings have taken place in order to progress the implementation of the CQC Self-assessment module within InPhase. A decision has now been agreed around the hierarchy in Q3. SaTH PMO are now working with the Inphase developer to define the next steps for the implementation and key stakeholders have been identified to establish a task and finish group to support this. There is an aim to complete by March 2023 for the planned maternity inspection. 3. IPC action plan developed and in place, and being delivered, with a re-inspection held on 12 December 2022. Inspection undertaken and RAG rated 'green' with sustainability visit planned March 2023.			**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 Diagnostic Task Group • NHSE 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 • Mutual aid request to regional mutual aid hub	**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) • Weekly Trust RTT 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 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, 78 weeks and 62 day weekly cancer call with NHSE and STW (3rd) • Cancer trajectories - 62 day backlog, and 28 day faster diagnosis to FPAC (2nd) • RTT - 104 and 78 week recovery trajectory to FPAC (2nd) • 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~~ June 2023 at PRH (phase 1 approved and phase 2 approved September 2022 with work commenced - part of Transformation Investment Fund). Ongoing works for move of renal outpatient dialysis from PRH to Hollinswood House - expected ~~March~~ July 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. Recruited into vacancies but currently super-numerary. Risk to staff retention if we cannot recover elective activity quickly. 3. Extra modular ward was due to be operational from start of August 2022 and now utilised for Critical Care on a temporary basis. Critical Care due to move back on w/c 6 February 2023 and then ward 26 will move from current accommodation into the new modular ward. 4. Unable to recruit to positions. Intend to go back out to advert in the new year. 5. Work complete October 2022 with ongoing refinement.			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 acute bed capacity and workforce. • Increase in complexity of demand and length of stay • 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 • 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 - monthly (2nd) • 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) (2nd). • 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 grade doctors. 2. Estate constraints at both sites Emergency Department (including 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 - to be completed 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~~ July 2023 with acute ward to be reconfigured once vacated. 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 and review of action plans - throughout 2022/23	1. Recruitment ongoing and in progress. 2. RSH ED works programme completed August 2022. 3a. Case approved and estates work underway to create acute floor. Open 15 December 2022. 3b. Underway. Delay due to community diagnostics centre business case. 4. Action complete. Acute floor open 15 December 2022. 5. Winter Plan produced and submitted to Trust Board in November 2022. 6. Expanding the use of virtual wards in frailty, cardiology and respiratory. 7. Reporting, review and monitoring continues.			**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	**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 patients and community									
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) • National Joint Investment Committee approval to proceed to OBC (3rd) reported to Trust Board Sept 2022	4	4	16	**Gaps in control:** 1. Following approval of the Strategic Outline Case (SOC), 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 **Gaps in assurance:** 3. Personnel, demand and capacity, dependency on system-wide programmes and governance to be expanded as part of outline business case stage.	**Actions aligned to gaps:** 1. Develop the outline business case (OBC) and submit to NHSE by mid-April 2023, prior to national Joint Investment Committee Meeting. Executive lead: Director of Strategy & Partnerships. 2. Await feedback from submission of second elective surgery hub scheme business case at end of September 2022. Executive lead: Director of Strategy & Partnerships. 3. 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 was approved by national panel 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 continues. (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 Our patients and community	**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**					
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). Lead: Shropshire Community NHS Trust 4. *Not a SaTH action to lead*	1. The Chief Operating Officer continues to attend the Local Care Programme meetings and Virtual Ward Oversight Group to provide support. 2. Chief Operating Officer participates in Local Care Programme. 3. This has moved (Q2) to a system approach led by Shropshire Community NHS Trust working with SaTH clinicians including the Clinical Director for acute medicine. Also support from Tim Taylor, national virtual ward clinical lead.			**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) • MIAA Ockenden review report in quarter 3 with Substantial assurance (3rd)	3	2	6	**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. Substantive resources in place are now becoming business as usual. 2. Trust continues to work with stakeholders and community members regarding access to maternity services.			3