The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
14 December 2023

Agenda item		165/23		
Report Title		**Board Assurance Framework – Draft Quarter 2, 2023/24**		
Executive Lead		Director of Governance – Anna Milanec		
Report Author		Interim Corporate Governance Consultant – Deborah Bryce		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	All BAF risks
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Quality & Safety Assurance Committee, 25 October 2023. Finance & Performance Assurance Committee, 31 October 2023. Audit & Risk Assurance Committee, 06 December 2023		
Executive summary:		The Board Assurance Framework (BAF) content has been thoroughly reviewed for quarter 2 of 2023/24 by the executive risk owners and their relevant senior team members. This includes a re-write of the previous year's BAF risk 2 with a very specific focus within the risk detail on safety culture, to eliminate the previous overlaps with BAF risk 1. BAF risk 2 remains an early draft and feedback is welcome on the risk content and score.		
Recommendations to the Board:		The Board is asked to: a) Consider if the BAF 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 the QSAC feedback provided on the BAF within sections 2.6-2.7. d) **Approve** the quarter 2 BAF for 2023/24.		
Appendices:		**Appendix 1**: Board Assurance Framework (draft) - Quarter 2		

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 BAF content for quarter 2 was undertaken during mid-September to mid-October 2023.

1.3 The Board's attention is drawn to all of the risks.

2.0 Significant changes to the BAF in quarter 2 2023/24 and feedback

2.1 The BAF content has been thoroughly refreshed for quarter 2. The draft quarter 2 BAF can be found within **Appendix 1.** New narrative since the previous quarter 1 2023/24 BAF is shown in blue text.

2.2 The Board did not agree to close BAF risk 2 (*The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience*) in quarter 1 as the safety culture risk element still required a specific focus. BAF risk 2 has, therefore, been re-added from the previous year with completely refreshed content, following consideration by Board of the previously proposed revised (merged) BAF risk 1. The risk title of BAF risk 2 remains the same as in previous years, but the revised specific safety culture content should now eliminate the previous overlaps with BAF risk 1. BAF risk 2 remains an early draft and feedback is welcome on the risk content and score.

2.3 It is proposed in quarter 2 to increase the total current risk score of BAF risk 12 (*There is a risk of non-delivery of integrated pathways, led by the ICS and ICP*) from 4x3=12 to 4X4=16, despite the score of BAF risk 12 being reduced in quarter 1. The risk score has increased again as we are not seeing the level of referrals onto the virtual ward that we have for planning purposes within the Operational Plan (2023/24), despite having the relevant actions in place.

2.4 The corporate governance BAF risk has been re-numbered from BAF risk 2 at quarter 1 to BAF risk 13 at quarter 2, following re-instatement of the safety culture BAF risk 2.

2.5 A few actions within the BAF risks have proposed extended target deadlines, and some risk actions are proposed to be closed within quarter 2, as indicated within the BAF.

2.6 At its meeting on 25 October, the Quality & Safety Assurance Committee (QSAC) agreed that there should be some further updates to BAF risk 2 to reflect the psychological safety and Civility Saves Lives work. This additional detail has now been added. QSAC suggested that the Board should hold a development session on safety culture and reflect on the score of BAF risk 2, as the likelihood score of the risk may be too high, although further consideration would be required on the mitigations in place for this risk. It was also recognised that BAF risk 2 had a wider remit than the executive leads assigned to this risk (Director of Nursing and Medical Director).

2.7 In addition, QSAC agreed that BAF risk 12 would benefit from further consideration during quarter 3 of the key clinical pathways and the Trust's involvement in these integrated pathways within the local health system.

3.0 Risks, actions and the Organisation's Top risks

3.1 The detail of each BAF risk and proposed actions aligned with gaps in control and assurance can be seen within the draft BAF (Appendix 1).

3.2 Based on the draft current total risk scores for the quarter 2 BAF in 2023/24, and a total of 14 risks, there are two top risks with a risk score of 20; eight risks with a current total risk score of 16; two with a score of 15 and two with a score of 12, as indicated within the BAF summary page.

3.3 The two top risks, with a current total risk score of 20, are shown below. These have not changed since quarter 1 2023-24.

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

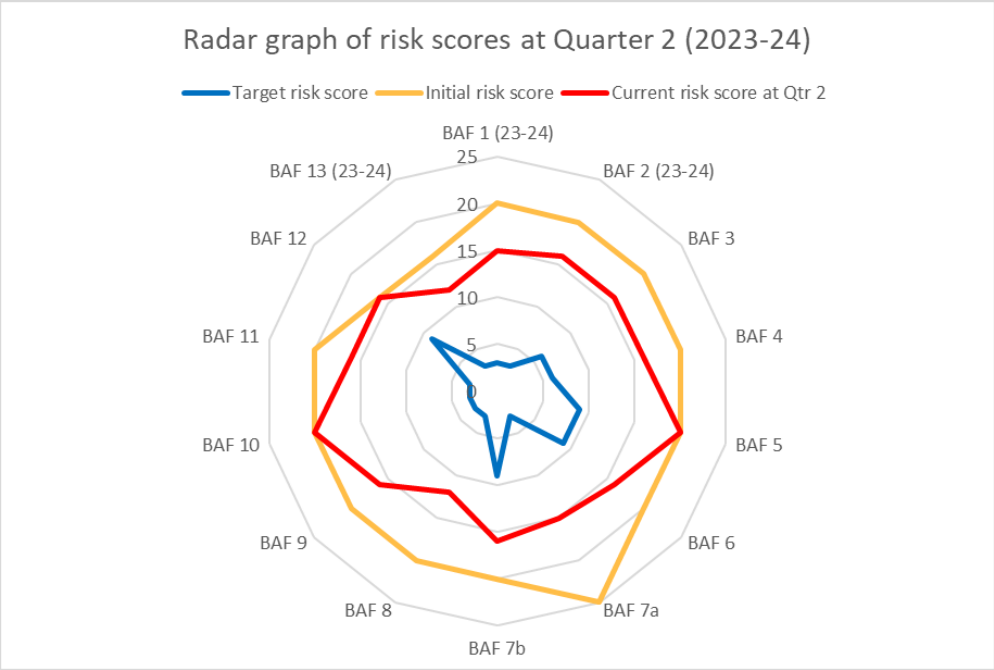
No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 2, 2023-24	Change since quarter 1 2023-24
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action.	Finance & Performance Assurance Committee	4x5 = 20	No change ↔
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Finance & Performance & Quality & Safety Assurance Committees	4x5 = 20	No change ↔

3.4 Being aware of the proposed top scoring risks (based on the current risk score) should assist the 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. The BAF summary page indicates the scores for each risk, which also includes other extreme risks scored above 15.

4.0 Visual representation of risk scores

4.1 The radar graph within the BAF (below) provides a visual representation of risk scores, including target risk score. It is intended that this will assist the 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 5, 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.



5.0 Recommendations

The Board is asked to:

a) Consider if the BAF 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 the QSAC feedback provided on the BAF within sections 2.6-2.7.
d) **Approve** the quarter 2 BAF for 2023/24.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework (BAF) 2023/24 - final draft quarter 2 (July-Sept 2023)

(Updated September/October 2023 - Version 1.3)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

											Current total risk score:	
Board Assurance Framework 2023/24 - Summary at Quarter 2 (July to September)		**Alignment to strategic goal(s)**	**Initial (inherent) risk score**	**Target risk score**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2022-23)**	**Quarter 3 (2022-23)**	**Quarter 4 (2022-23)**	**Quarter 1 (2023-24)**	**Quarter 2 (2023-24)**	**Change in current risk score between Q1 and Q2, plus any further comments**
BAF 1 (23/24)	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	We deliver safe and excellent care first time every time.	5x4 = 20	3	Medical Director /Director of Nursing	Quality & Safety Assurance Committee	N/A	N/A	N/A	5x3 = 15	5x3 = 15	↔ No change.
BAF 2 (23/24)	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	4x4 = 16	BAF risk 2 content from Q4 22-23 refreshed with a specific focus on safety culture (title remains the same). ↔ No change in risk score.
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	People & OD Assurance Committee	4x4 = 16	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	People & OD Assurance Committee	5x4 = 20	5x4 = 20	5x4 = 20	4x4 = 16	4x4 = 16	↔ 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	4x5 = 20	4x5 = 20	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	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 Strategy & Partnerships	Audit and Risk Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	↔ No change
BAF 7b	The inability to implement modern 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 Strategy & Partnerships	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change.

Board Assurance Framework 2023/24 - Summary

										Current total risk score:	
Board Assurance Framework 2023/24 - Summary at Quarter 2 (July to September)		**Alignment to strategic goal(s)**	**Initial (inherent) risk score**	**Target risk score**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2022-23)**	**Quarter 3 (2022-23)**	**Quarter 4 (2022-23)**	**Quarter 1 (2023-24)**	**Quarter 2 (2023-24)**	**Change in current risk score between Q1 and Q2, plus any further comments**
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	4x3 = 12	4x3 = 12	↔ 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	4x5 = 20	4x5 = 20	4x5 = 20	4x4 = 16	4x4 = 16	↔ 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	4x5 = 20	4x5 = 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 Hospital Transformation Programme	Finance & Performance Assurance Committee and HTP Sub-Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led 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	4x4 = 16	4x4 = 16	4x4 = 16	4x3 = 12	4x4 = 16	↑ Risk score increased from 12 to 16 as we are not seeing the level of referrals onto the virtual ward that we have for planning purposes within the operational plan (23/24), despite having the relevant actions in place. The biggest impact on beds and patient flow is the use of the virtual ward.
BAF 13 (23/24)	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	We deliver safe and excellent care first time every time.	4x4 = 16	3	Director of Governance	Audit and Risk Assurance Committee	N/A	N/A	N/A	4x3 = 12	4x3 = 12	↔ No change in risk score. Now re-numbered from BAF risk 2 (at Q1) to BAF risk 13 (at Q2).

The Shrewsbury and Telford Hospital NHS Trust

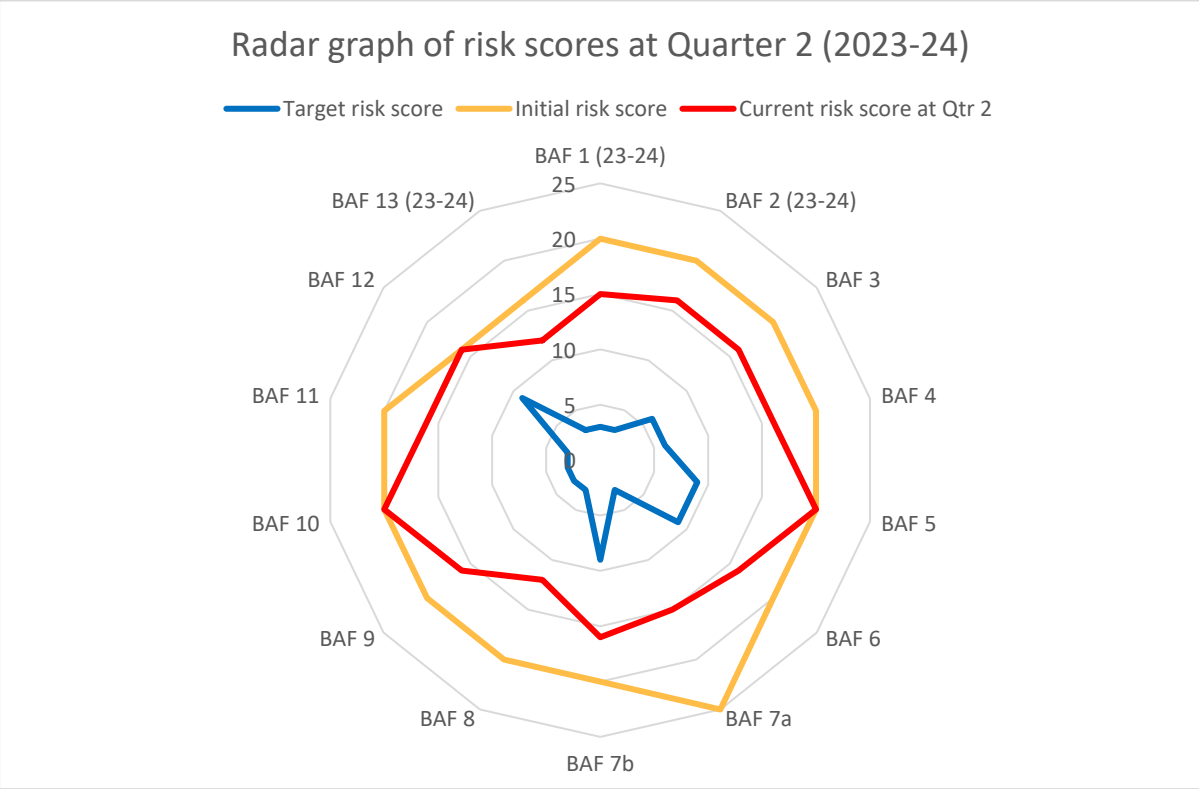
Risk scoring framework

	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 (23/24): **If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will be unacceptable.**			**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: risk content refreshed 1 April 2023 (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 care • Inconsistencies and lack of clarity in governance arrangements • Lack of resources • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies • Operational pressures • Workforce gaps (including vacancies); Inability to recruit and retain the right numbers and skill mix of clinical staff • Clarity of and lack of consistency in the use of policies and procedures • Unable to off-load ambulances in a timely way because of lack of patient flow through the organisation • Industrial action • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture **Consequence:** • Harm to patients • Delays in time-critical care • ~~Wrong~~ Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • Further CQC prosecutions and enforcements if standards and frameworks are not in place. • Ambulance rapid handover could result in a greater volume of patients in ED than can be received and cared for • Reputational damage, financial loss and lack of confidence in the organisation • Increase in use of temporary and agency staff resulting in lack of continuity and financial pressures	5	4	20	• Getting To Good (G2G) workstreams: Levelling up Clinical Standards and Fundamentals in Care. • Targeted transformation programmes • Quality Strategy; Quality Priorities; Corporate Strategy; People Strategy; Digital Strategy; workforce planning • Clinical audit programme • Learning from Deaths Group review • Deteriorating Patient Group • Falls prevention strategy • Safeguarding Policy (including Mental Health and Learning Disabilities) • IPC Policy • Palliative and End of Life framework • Staff training • Identification and management of concerns about 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 • Exemplar programme (ward accreditation) • Monthly Nursing Metrics • Daily incident communications (Datix) • Pressure ulcer panels • Nutrition and Hydration Group • Nursing Documentation Group in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance Visits • Weekly clinical leaders forum • Newsletters shared • Quality Matrons • Patient Safety Specialist in post • SaTH improvement methodology courses • SaTH Improvement Hub • Clinical Lead for Improvement in place • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Patient and Carer Experience Panel (PACE) - Trust wide and speciality groups	**Reported to Board, committees and elsewhere:** Non-Executive led assurance committees: • Quality & Safety Assurance Committee and Ockenden Report Assurance Committee, reporting to Board (2nd) • Mortality metrics reported to Board and Learning from Deaths Group considered by Board quarterly (2nd) • Quality metrics within Integrated Performance Report to Board (monthly)(2nd) • CQC Report, published November 2021 provides assurance that improvements are being made across the Trust and CQC maternity survey - February 2021 (3rd) • CQC Mock inspections (2nd) • SATH Oversight and Assurance Group (3rd) • Quality Account to QSAC/Board (2nd) • Serious incident reports, themes, claims and complaints report to QSAC and public Board (2nd) • Staff Survey results to Board and quarterly pulse survey results considered at People & OD Committee (2nd) • Executive chaired assurance committees: Quality Operational Committee; IPC; Safeguarding; Nursing, Midwifery, AHP and Facilities Workforce; Maternity Transformation Assurance Committee (MTAC); NIQAM (nursing incidents quality assurance meeting); RALIG (review and learning from incidents); Emergency Care Transformation Assurance Committee (ETAC); Patient and Carer Experience Panel; Paediatric Transformation Assurance Committee (PTAC) - reports into QSAC (2nd) • Performance Management Review Meetings (PRM) with Divisions, executive led (2nd) • Internal Audit reviews considered at Audit & Risk Assurance Committee - Quality Spot Checks, Complaints Management, End of Life Pathways; Ockenden (maternity) progress; Safeguarding; and Falls (3rd) • External audit review report (KPMG) of VFM in 2022-23 (3rd) • Operational groups: IPC; Safeguarding (children and adults); Quality Metrics; Falls; Confirm and Challenge; Nutrition and Hydration; Palliative End of Life Care Steering Group; Pressure Ulcers, Rapid Review; Getting to Good review meetings; Flow Improvement (1st) • Culture dashboard reported to Operational People Group (1st) • Externally led quality assurance visits and reports - e.g., NHSE, HEE (now NHSE), ODN's, ICB, and other regulators - paediatric visit, safeguarding and ED visit regarding ambulance offload delays 2022 (3rd) • Updated FTSU Policy to June 2023 Board (2nd) • Quarterly FTSU updates to Board (Oct 2023) (2nd)	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. doctors within critical care, care of the elderly, emergency medicine, and significant gaps in nursing, including paediatric and neonatal, and nurse associates. 2.-Increased number of patients with no criteria to reside, impacting on patient flow and pressures in the Emergency Department. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Implementation of national Patient Safety Incident Response Framework (PSIRF). 5. Standardisation of education for clinical ward leaders to ensure standardised approach across the organisation. 6. Lack of Policies and Procedures Group to sign-off clinical policies, plus no overarching Documentation Group. 7. Assurance framework to oversee smaller clinical regulator requirements (e.g., HTA, HFEA, UKAS and MHRA) **Gaps in assurance:** 8. Information/KPI's to indicate quality strategy is being delivered. 9. Oversight of serious incident actions	Actions aligned to gaps: 1a.Workforce planning - see BAF risk 3 plus Workforce Strategy. 1b. Delivering the trajectories within the Workforce Strategy . Leads: Kara Blackwell and Simon Balderstone. During 2023 and 2024. 2a. See BAF risk 10. 2b. Progression of OBC for Hospital Transformation Programme - link to BAF 11 2c. Deliver ~~SaTH~~ System UEC improvement programme by 31 March 2024 - Executive Lead: ~~Chief Operating Officer~~ Director of Delivery & Transformation, ICB ~~2d. Delivery of actions outlined within the Urgent Care Transformation (SaTH) - by March 2026 . Executive Lead: Chief Operating Officer~~ *(deleted, as action 2c will cover 2d).* 3. Electronic Patient Record planned by end of 2025. New patient administration system (PAS) to be in place ~~by Summer 2023~~ as per agreed implementation plan (see BAF risk 7b). Executive lead: Director of Strategy & Partnerships. 4. Implement PSIRF roll-out programme by end of November ~~September~~ 2023. Executive Lead: Director of Nursing 5. Introduce a programme of development for clinical leaders (including nursing, midwives and AHP's) by Q4. Executive Lead Director of Nursing. 6. Policy Framework including Policy for Policies' to be reviewed. Executive Lead: Director of Governance, by December 2023. 7. Development of the framework and agreed governance routes. Executive Lead: Executive Medical Director, by December 2023. 8. Develop quality strategy dashboard by August 2023. Executive Lead: Director of Nursing 9. Ensure better oversight/reporting of serious incident actions progress: discuss and agree serious incident reporting with the Divisional leadership team - the tracked actions also need to be part of the PMO process by Q2 2023-24. Executive Lead: Director of Nursing	2b. Work ongoing (see BAF risk 11) 3. Digital roadmap being followed with plans for new patient administration system (PAS) ~~to be in place by Summer 2023~~ as per agreed implementation plan. 4. Work is ongoing internally and across the system. PSIRF Plan and Policy to Board October 2023. 5. The programme is currently being scoped so that a draft programme can be developed and approved prior to the Q4 deadline. 6. Associate Medical Director appointed (Q4 2022-23) whose portfolio will include reviewing governance of clinical guidelines. Policy framework currently under review (see BAF risk 13) 7. The first of these meetings were held on 2nd October 2023 and the discussions will be used to form the basis of further quarterly meetings. 8. The Quality and Safety dashboard has now been developed (Q2) and has gone live with data up to August 2023. This will be monitored and reported through QSAC. (*Propose to close action)* 9. Qtr 2: Actions from Serious Incidents are uploaded and tracked through the Datix system. Review of all open actions has been undertaken and an overview of status of open actions by Division will be presented in the Serious Incident Overview Report to QOC in November. From December 2023 each Divisional Governance and Safety report will detail the number of open actions for Divisional oversight and will be reported in the monthly QOC report. (*Propose to close action in Q3*)			3

Revised draft

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 2 (23/24): 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: risk content fully revised Q2, 2023/24 (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: • Inconsistent leadership to support a high quality compassionate care environment • Inconsistent embedding of learning when colleagues speak up • Inconsistent approach to ensure acceptable values and behaviours that create psychologically safe team working • Inconsistent organisational support to embed a continuous learning and improvement environment • Leaders inconsistently demonstrating basic good practice in respect of 1 to 1 meetings, health and wellbeing check ins and talent management conversations with colleagues. • Lack of prioritisation of learning and development for colleagues. **Consequence:** • Increased harm • Poor patient experience • Increased complaints • Reputational damage • Lack of confidence in the organisation • Further CQC prosecutions and enforcements • Our people are not routinely raising concerns/speaking up on patient safety and anything else that may affect great patient care • Our people do not work as a team and a safety culture is not embedded within the organisation • Poor communication and unable to learn from incidents • Lack of measure of safety culture within the organisation	5	4	20	• Embedding NHS Impact within Getting To Good (G2G) workstreams • Freedom to Speak Up Guardian and ambassador arrangements • FTSU Vision and Strategy in place • New national FTSU 2022 policy update in place • FTSU on-line training is mandatory at SaTH (since June 2022 - at 8 October: FTSU workers at 86%, FTSU managers at 72% and senior leaders 54%) • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance visits • Patient Safety Specialist in post • SaTH improvement methodology courses • SaTH Improvement Hub • Trust Strategy 2022-2027 (includes continuous improvement culture) • Leadership programmes in place, including Galvanise programme for colleagues from ethnic minorities • Continuous improvement programme • Staff psychological wellbeing services in place • Staff Survey covers some key safety culture elements (being undertaken Oct to Nov 2023) • PSIRF Plan and Policy (for 1 December 2023 implementation) • Civility and Respect workshops in place in the Trust that are available for clinical and non-clinical teams (1,000 plus people have taken part in these workshops, at October 2023) • Head of Culture in place with Civility and Respect remit • Neutral evaluations take place within teams in certain areas • Internal cultural reviews taking place via OD Team, with subsequent cultural interventions put in place, where required, e.g. team workshops and signposting to leadership courses.	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) • ORAC - Ockenden Report Assurance Committee (2nd) • Culture dashboard (annually based on Staff Survey) and quarterly cultural report, reported to Operational People Group (1st) • Updated FTSU Policy approved at June 2023 Board (2nd) • Quarterly FTSU updates to Board (Oct 2023) (2nd) • Patient Safety Incident Response Framework and policy to October Board (2nd) • Internal audit of FTSU arrangements (in-house) Sept 2022-May 2023 (2nd)	4	4	16	**Gaps in control:** 1. Delivery of the five components of NHS Impact: • Building a shared purpose and vision • Investing in people and culture • Developing leadership behaviours • Building improvement capability and capacity • Embedding improvement into management systems and processes 2. Embedding the new approach to patient safety 3. Evidence of continuous quality improvement culture 4. Colleagues feeling safe and supported to raise patient safety concerns (FTSU and raising risks and incidents), and that they will be acted upon and learning embedded. 5. Clinical Lead for Improvement gap **Gaps in assurance:**	**Actions aligned to gaps:** 1a. Develop and agree the Getting to Good Plan for each of the NHS Impact five continuous improvement components, including executive lead, by November 2023. Executive lead: various/TBC. 1b. Co-ordinated programme to respond to NHS Impact, monitored through Getting to Good Programme (during 2023/24 and 2024/25). NHS Impact Self Assessment to be completed by 31 October 2023. Executive Lead: Director of People & OD and Director of Strategy & Planning. 1c. Embedding the Just Culture Framework and linking to workforce policies and procedures, during 2024-2026. Executive lead: Director of Nursing. 2a. Implement Patient Safety Incident Response Framework (PSIRF) by November 2023. Executive lead: Director of Nursing 2b. Continuous dissemination of learning from incidents *2c* Develop a three year Patient Safety Strategy by April 2024. Executive Lead: Director of Nursing 3a. Deliver Improvement Conference in May 2024. 3b. Review Staff Survey Results in January/February 2024 with Divisional action plans put into place by April 2024. Executive Leads: All 4a.Board to undertake FTSU self-reflection by November 2023 and then develop FTSU Trust priorities by end January 2024. Executive Lead: Director of Governance 4b. Board to consider their role in creating/modelling a speak up/psychologically safe culture at SaTH, along with associated actions - at the 1 November 2023 Board FTSU self reflection session. Executive Lead: Director of Governance, along with Non-Executive Director FTSU lead. 5. Appoint Clinical Lead for Improvement by 31 March 2024. Executive lead: Medical Director	1a. G2G Plans drafted, initial conversations with SLC completed. Plan to have a regular slot on SLC in future. 1b. Engagement conversations started with leads in respect of the self-assessments. 2. PSIRF Plan and Policy scheduled at October 2023 Board meeting. 3a. - 3b. Staff Survey currently live (Oct-Nov 4. October 2023 is FTSU month with publication of FTSU learning across the Trust . Board FTSU self-reflection session scheduled for 1 November 2023.			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.**			**People & OD Assurance Committee**					
				Our patients and community									
Risk opened: 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 • Dissatisfaction with pay and reward • Work environment concerns in relation to belonging and staff experience relating to behaviours **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. • Industrial action • 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 • Inclusion Improvement 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 Consultant 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 - recruiting 203 in 2023/24. • 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. • Developed operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan	**Reported to Board, committees and elsewhere:** • Reports to People & OD Assurance 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) • Financial Governance Group - weekly (2nd) • Executive dashboard on agency expenditure - weekly (1st)	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. 9. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. **Gaps in assurance:** 10. Employee relations practice in relation to harassment and discrimination.	**Actions aligned to gaps:** Executive Lead for actions: Director of People and Organisation Development. 1. Deliver and embed management technical competency framework for bands 3 to Board - by March 2024. 2. Workforce Planning Steering Group established. Guidance and template workforce planning approach linked to Skills 4 Health training to support organisation and system in relation to workforce planning - training to be completed by September 2023. 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 2024. 4. Implementation of the people services improvement plan by August 2023 which includes full review of all medical rosters ensuring compliance (by March 2024). 5. Review of SaTH People Plan Strategy with updated actions by December 2023, aligned to the organisation strategy and NHS Long Term Workforce Plan. 6. Embed and deliver annual reward and recognition practices across the Trust by March 2024. 7. Embed Talent Management Approach - by March 2025. 8a. New development programmes in place for 2023/24 which continues the expansion of new roles and apprentices across the Trust, aligned to the NHS Long Term Workforce Plan by March 2024. 8b. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure development of staff people plan by July 2024. 9a. Board and executive team must have EDI objectives that are SMART and be assessed against these as part of the annual appraisal process, by March 2024. 9b. Board members should demonstrate how organisational data and lived experience have been used to improve culture, by March 2025. 9c. The Board must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework, by March 2024. 10. External review of recent cases to establish lessons learned and improve employee experience by December 2023.	1. Formally launched competency framework for new managers in November 2022 as part of Trust Recognition Week. Pilot programme reviewed and cohort two commenced 24 April 2023. STEP and SaTH 1-4 Leadership Programmes delivered as part of business as usual work. 2. **Action complete Q2, 23-24.** 3. Home Working Policy updated and ~~to be~~ launched quarter 2. Gathering information about home working practices to allow impact assessment to inform future incentives to improve space utilisation. National Homeworking Policy has now been released and reviewing SaTH policy on this basis during Q3. 4. Work on the plan was concluded August 2023. Work continues on reviewing and implementing changes to rotas across junior doctor specialities. 5. Draft ICS People Plan submitted to ICB March 2023. Local alignment to SaTH People Plan and national NHS Long Term Workforce Plan during quarter 3. Collaborative working across the system to align People Priorities and maximise resource. 6. In progress and on track for delivery at Q3. 7. Talent approach agreed. Talent briefings held. Talent portal launched. Talent Conversations training will commence in quarter 3. 8a. On track with new roles, in accordance with the Trust's Operational Plan, e.g. nursing associates. 8b. Commenced review of health and wellbeing framework diagnostic tool - pilot in place, further discussion about integration into normal business planning process. MIAA commencing health and wellbeing audit in Q3. Looking to support Divisions to undertake the diagnostic tool, as risk in capacity available to do this. 9. Actions 9a-9c have been taken from the NHS equality, diversity and inclusion improvement plan, published 8 June 2023. Board development session awaited. ~~to be considered during October 2023.~~ Currently reviewing the Wellbeing & Health Inequalities Strategy with the Director of Strategy & Planning (previously called EDI Strategy). 10. The review has been commissioned and is underway.	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.**			**People & OD Assurance Committee**						
				Our patients and community										
Risk opened: 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. • Increasing agency costs if we are unable to recruit fully	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 • Civility Saves Lives programme roll out • SaTH education offer via education prospectus • SaTH 1 to 4 and STEP Leadership Programmes • Affina team journey interventions	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee (2nd) • Operational People Group (OPG), monthly (2nd) • Education Group (1st) • System education/training meeting (1st) • Culture Group reporting and culture dashboard to Operational People Group (1st) • Retention Group reports into 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) • People Pulse Surveys reported to OPG quarterly (2nd) • EDI reporting into EDI Performance Group, which feeds into OPG (1st)	4	4	16	**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. Lack of systematic approach to talent management and succession 5. Embedding of trust values consistently at every level and within all key systems and processes 6. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 7. High levels of mental health related sickness absence **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Director of People and Organisation Development. 1. Continue to embed stay conversations and embed exit interview process - by December 2023 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 2023/24. 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 2024. 3b. Continue workforce transformation programme which includes new roles and new ways of working - in place by March 2024. 4a. Continue to support the Scope for Growth programme as part of wider succession planning and talent mapping - by March 2024. 4b. Deliver and embed management technical competency framework for bands 3 to Board - by March 2024. 4c. Evaluate the Leadership & Development Strategy and Programme for compassionate, inclusive and effective leadership - by October 2023. 5. Communication to re-energise vision, values and behavioural framework by July 2023. 6. Refresh and deliver EDI action plan and review against key workforce data to include review of newly published NHS EDI Improvement Plan, by March 2025, with report to Board at least annually in October. 7. Embed and develop the new staff psychology service by March 2024.	1. 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 - part of retention programme. Exit interview group established. Hot spot areas being identified. Some risk flagged in respect of Divisional capacity to undertake 'stay conversations'. Support is being provided to ensure conversations form part of normal 1 to 1 meetings. 2. Worked through national PSIRF guidance in relation to how we react to incidents nationally and monitor this. People Advisory Team and Improvement Hub supporting this work. 3a. Home Working Policy launched quarter 2. Gathering information about home working practices to allow impact assessment to inform future incentives to improve space utilisation. Working party group has been established and flagship programmes as part of the staff survey, and retention group. National Homeworking Policy has now been released and reviewing SaTH policy on this basis during Q3. 3b. Workforce transformation governance framework (HTP) in place July 2023. ~~September 2023.~~ 4a. Ongoing. As part of our talent management approach, we completed the scope for growth pilot and is now embedded in our STEP management skills programme. 4b. Formally launched competency framework for new managers in November 2022 as part of Trust Recognition Week. Pilot programme reviewed and cohort two commenced 24 April 2023. STEP and SaTH 1-4 Leadership Programmes delivered as part of business as usual work. 4c. Compassionate inclusive and effective leadership integrated into our leadership programmes and masterclasses following review of the Leadership Framework. Update expected at OPG in Q3. 5. Values Week launched 5th -9th June 2023 to re-energise the Values and engage our workforce in Values related activities. **Action complete, Q1.** 6. 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 and due again 12 October 2023). Annual equality reports and gender pay reports approved by Board - March 2023. Currently reviewing the Wellbeing & Health Inequalities Strategy with the Director of Strategy & Planning (previously called EDI Strategy). 7. Quarterly monitoring of activity and impact on sickness absence and mental health to be put in place via quarterly monitoring to OPG from September 2023. Regular monitoring via OPG in place (Q2). Staff Psychology service has developed a number of interventions such as debrief training for ED department (Q2).			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: 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 • ~~Inflation: energy costs~~ • Continuing to operate in a system with a commissioner deficit **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 • Inhibits ICS' ability to commission growth in services	4	5	20	• 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 2023/24 that was developed with specialty input and within which activity, workforce and finance triangulate (1st) • Reviewing junior doctors rotas to ensure compliance	**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) • 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) • Five Year Financial Plan presented to FPAC January 2023 (2nd) •Weekly Executive Meeting dashboard: beds, WTE and finances (2nd) • CIP follow-up review by MIAA - October 2023 (3rd)	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 on a daily basis leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost in relation to both medical and nursing staff. 6. Understanding how SaTH 5 year plan feeds into health system financial plan. **Gaps in assurance:** 7. Evidence of effective budget surgeries (monthly meetings to review budgets).	**Actions aligned to gaps:** 1. Continue to engage divisions in a multi-year cost improvement efficiency pipeline to close the gap - by July 2023 (and by November 2023 for 2024-25 financial plan). Executive lead: Director of Finance. 2a. Controls implemented in line with conditions set out within the plan approval letter from NHSE by July 2023. Executive lead: Director of Finance. 2b. Review of entry points for substantive and temporary nurses and medics to ensure sufficient processes and procedures are in place, by September 2023. Executive lead: Director of HR & OD. 2c. External audit completed for 22/23 with six recommendations and associated action plan which will continue during 2023-24. 3a. Continue delivery of financial training across the organisation with dedicated training for Clinical Directors to be addressed - by end Q3 ~~August~~ 2023. Executive lead: Director of Finance. 3b. Level 2 Future Focused Finance accreditation received May 2023, now working towards Level 3 accreditation by Summer 2025 ~~December 2024~~. Executive lead: Director of Finance. 4. Internal User Group identifying gaps in Oracle system performance to develop a workplan to be shared with ShropComm (system hosted by ShropComm) by October 2023. Executive lead: Director of Finance. 5a. Use of the Safe Care Model for nursing and compliant junior doctor rotas by December 2023. Executive lead: Director of Finance/Director of Nursing/Director of People & OD/ Medical Director. 5b. Develop a ward/speciality level recruitment trajectory for both medics and nursing, taking into account both domestic and international recruitment by December ~~July~~ 2023. Executive Lead: Director of People & OD. 6. Require system-led action to do this work. Executive lead: Director of Finance *7a* . Re-review of budget surgery agendas and actions log by ~~August~~ November 2023. Executive lead: Director of Finance. 7b. Robust methodology for benchmarking of budgets by ~~September~~ December 2023 against widely available peer data to inform future budget setting and the efficiency pipeline. Executive lead: Director of Finance.	1. Meetings scheduled and considering support for Divisions to identify and deliver further efficiencies - July 2023 action complete. Additional support in place for all divisions to support additional identification and delivery of efficiencies (Q2). 2a. Work underway. Reviewed controls outlined within the NHSE letter and implemented additional controls where necessary - action closed. 2b. Update sought 2c. In progress. 3b. Unable to apply for Level 3 until ~~12~~ 24 months after achievement of Level 2. 4. Work underway. 5a. and 5b. Work underway. High level recruitment trajectory for medics and nursing developed, this is now being cascaded down to individual ward/speciality level. 6. ICS have developed business case for additional support to develop this. Work is now underway: business case has been approved and work has been commissioned. 7a. and 7b. Work underway. Finance project steering groups have been set up with seven workstreams, one of which is concentrating on budget setting.			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: 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. • The Trust has identified reinforced autoclaved aerated concrete (RAAC) within specific areas within PRH and surveys continue across the Estate. **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) • Minor and major works protocols and management plans in place for known risks, e.g. asbestos and RAAC.	**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 (1st) • Regular updates of fire action plans at Fire Safety Group (1st) • Fire Safety Improvement Action Plan Oversight Group (2nd) • Fire Safety Training Task & Finish Group (providing oversight) (2nd) • Fire safety updates reported to private Board regularly (2nd) • Operational estates governance and oversight in place including: Decontamination Group (2nd), Medical Gas Committee (2nd), Ventilation Safety Committee (2nd), Water Safety Committee (2nd), Fire Safety Group (2nd), Asbestos Safety Committee (2nd).	4	4	16	**Gaps in control:** 1. Energy infrastructure at its limit on the site 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. Lack of senior leadership capability within the Estates function/team **Gaps in assurance:** -	**Actions aligned to gaps:** 1a. Updated Energy Security Strategy to Board by July 2023. Executive lead for SaTH: Director of Finance. 1b. Energy Security & Decarbonisation Programme to be progressed throughout 2023-2028 . 2. Review/refresh Estates risk register and re-establish Estates Compliance & H&S Group - by August 2023. 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. Recruit to Director of Estates position by December 2023. Executive lead: Director of Finance	1a. Plans in place to improve the energy supply and to improve it in stages to supply the Trust plans up to then, and then including, Hospital Transformation Programme. High Level Energy Security Strategy submitted to Board. **Action complete Q2.** 1b. Signed up to increase in electricity supply in Sept 2023. Work ongoing. 2. Group re-established. Work complete. **Action complete Q2**. 3. Initial action complete and remains ongoing and is a continuing project. Escalation continues to Capital Planning Group where access to areas is not available, e.g. to address air handling units and passive fire protection works . Also raised at Infection Prevention Control Assurance Group. 4. Director of Estates job description is drafted. The whole of capital projects is now integrated with Estates as one team as of 10 July 2023.			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 Strategy & Partnerships**	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 was subsequently split out into risk 7a and 7b from 2022-23.			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: • 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 (note: this area is subject to further expansion) • 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) - DSPT is due to evolve further with a greater focus on cyber which will increase a lot of the controls in place • 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 2023 - Substantial level of assurance provided in respect of the self-assessment. Moderate assurance level overall against the 10 National Data Guardian standards) (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 (Cyber report due to be reported from SaTH Information Governance Group to ICB Digital Group from October 2023).	5	3	15	**Gaps in control:** 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours. 3. Cyber Security strategy to be developed. **Gaps in assurance:** 4. Medical device assurance report.	**Actions aligned to gaps:** 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions by 31 October 2023. Executive lead: Executive Lead: Director of Strategy & Partnerships 2. ~~ICS led review of cyber strategy, capability and capacity following approval of ICS Digital Strategy. Executive Lead: ICB Chief Medical Officer (ICB Executive Digital Lead).~~ SaTH to review cyber requirements to align with the ICS Digital Strategy, once approved. Executive Lead: Director of Strategy & Partnerships, by end October 2023. 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by 31 March 2024. Executive Lead: Director of Strategy & Partnerships 4. Develop medical device security report by 31 December 2023. Executive Lead: Director of Strategy & Partnerships	1. 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. At Q4 22/23: non-compliant exception report remains in place with regular meetings with divisional representatives to manage remediation. NHS England have had sight of exception report with revised completion date of plan by 31/10/23 for remaining non-compliant systems. A timetable to full compliance will follow. Regular report remains ongoing to corporate Information Governance Group. Due to provide update report on cyber position to Audit & Risk Committee Q3. 2. ICS Digital Strategy in draft and in the final stages of its approval process. Cyber capacity and capability will require development as part of the work programme of the ICS Digital Delivery Group. 3. Content and format of strategy under development. 4. Content and format of report under development.			3

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee					
BAF 7b: The inability to implement modern digital systems impacts upon the delivery of patient care			**Director of Strategy & Partnerships**	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 was subsequently split out into risk 7a and 7b from 2022-23.			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: • Lack of core project team resource - appropriate skillsets and experience and national shortage of digital technical personnel • Lack of capacity and capability within Trust • Large scale business change programme alongside other competing business change programmes • Network replacement • Patient Administration System replacement (move from SemaHelix to CareFlow PAS) along with a suite of software modules as part of a multi-phase, multi-year electronic patient record implementation). • Prescribing and Medicines Administration (EPMA - electronic prescribing and medicines administration) system required - funding secured provisionally for 2024/25. • Order Communication system is past the end of its useful life • 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 • Continuing national funding **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 • Inability to report • Potential regulatory action • Reputational damage and negative impact on public confidence • Potential negative impact on staff morale • Inability to operate in an integrated health and care system, e.g. shared care records	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 Committee, 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 (currently vacant) along with Clinical Safety Committee (safety of software and reducing hazards for patient safety) • Chief Nursing Information Officer in place • Director of Digital Transformation/Lead in place - at SaTH • New Chief Clinical Information Officer in place within the 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 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) • Report to STW ICS Digital Delivery Group (2nd) • 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. Requirement for key roles in the EPR programme - still working with agencies and Procurement for the remainder of the programmes to fill posts. 2. ~~Additional governance group required to assess operational readiness~~ *(no longer perceived to be a gap at Q4 2022-23)* 3. Capacity within wider trust teams for implementations 4. EPMA and Order Communications implementation/ sequencing and neonatal system implementation funding. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Work with agencies and procurement to appoint into vacant digital positions as they arise during 2023-24. Executive lead: Director of Strategy & Partnerships 2. ~~EPR Operational Readiness Group to be established by July 2022. Executive lead: Director of Strategy & Partnerships~~ *(action complete Q4)* 3. Detailed testing, training and process development plans created for each division and function, initially by June 2023, with ongoing regular review. Staff being planned for user acceptance testing (phase 2) and training plan (by end Sept 2023) to support the overall implementation plan. ~~by end September 2023~~. Executive lead: Director of Strategy & Partnerships 4a. Appoint a project team and develop Project Initiation Document for EPMA and Order Comms project. Project expected to commence quarter 4 2023/24. Executive lead: Director of Strategy & Partnerships. 4b. Neonatal business case funding to be sought for increased scope. Timeline may be dependent upon securing national funding. Executive lead: Director of Strategy & Partnerships	1. Digital positions ~~previously~~ continue to be appointed to, but we continue to have high turnover rates which reflects the current market position. 2. ~~In the current phase of the programme, we established four operational readiness groups (one for each clinical division), taking the place of the single group.~~ **Action closed** (Q2 2023/24). 3. Detailed plans for user acceptance testing phase 1 (June 2023) were completed. Training plans at departmental and individual staff member level have been produced. Final process maps in development - to be incorporated in user acceptance testing phase 2 (September). 4a. EPMA and Order Communications funding secured 22/23. 4b. Currently with the Women & Childrens division to secure funding to cover the increased scope of the neonatal system.			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**		**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: 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 • At the end of Q1 2023/24 the Trust has five Section 31 conditions in place	4	5	20	• Getting To Good (G2G) workstream: Quality & Regulatory Compliance • Quality Strategy 2021-2024 • Quality priorities • 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 • 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 • Board Assurance visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • Planned maternity CQC inspection in 2023 • Current regional Insight visit for first Ockenden Report which focused on immediate and essential actions. • Visible quality boards within ward areas.	**Reported to Board, committees and elsewhere:** • Reports received monthly at Quality Operational Committee (2nd) Quality & Safety Assurance Committee (QSAC) reports received (bi-monthly) and monthly via AAAA 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 - QSAC (2nd) • RALIG and NIQAM meetings (1st) • Rapid Review process reporting (1st) • Patient & Carer Experience Group (1st) • Mortality Group (1st) • Deteriorating Patient Group (1st) • Infection Prevention and Control (IPC) Assurance Committee (2nd) • Safeguarding Assurance Committee (2nd) • Operational meetings for IPC, safeguarding, workforce and maternity (1st) • 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, Healthwatch, NMC, GMC and HEE/NHSE attend attend (3rd) • External audit were satisfied in their Value For Money opinion that no significant weaknesses remain in 2021/22 relating to maternity services and 22/23 (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) • Getting To Good Operational Delivery Group (1st) which feeds into QSAC and Board • MIAA internal audit reports 2022/23 (3rd): End of life pathways - CQC action plan (substantial assurance); management of Ockenden 1 (substantial assurance); and quality spot checks (moderate assurance). CQC inspection undertaken on 10th and 11th October 2023, with Well Led due on 14th and 15th November - report due.	4	3	12	**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. *No longer perceived to be a gap at Q2* **Gaps in assurance:** 3. Information/KPI's to indicate quality strategy is being delivered (*as per BAF risk 1*).	**Actions aligned to gaps:** 1. System leadership required. 2. ~~TBC~~. N/A 3. Develop quality strategy dashboard by August 2023. 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. Children and Young People mental health summit occurred in September 2023 - awaiting next steps. 2.The CQC Self-Assessment tool has gone live and has been used (Q1). Decision made to use Monday.com (already used for emergency, paediatrics and maternity transformation programmes -Q2). The Trust is not adopting Inphase in its totality and will continue with in-house CQC self-assessment tool based on the CQC inspection framework. 3. The Quality and Safety dashboard has now been developed (Q2) and has gone live with data up to August 2023. This will be monitored and reported through QSAC. (*Propose to close action*)			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			**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: 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 (FPAC) (2nd) • Performance Highlight Report to FPAC, including RTT, Cancer, theatre productivity, outpatient transformation and UEC assurance (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 assurance meeting - 104, 78 weeks, 65 weeks, 62 day cancer backlog and 28 day faster diagnosis performance with NHSE and STW (3rd) • Cancer trajectories - 62 day backlog, and 28 day faster diagnosis to FPAC (2nd) • RTT - 104, 78 and 65 week recovery trajectory to FPAC (2nd) • DMO1 (diagnostics)recovery trajectory to FPAC (2nd) • Weekly UEC assurance meeting (1st)	4	4	16	**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 elective activity on both sites 4. Insufficient outpatient booking/scheduling staff 5. Outpatient transformation standards still not being fully achieved **Gaps in assurance:** -	**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 (in place). Improve overall radiology workforce/recruitment by March 2024. Executive lead: Chief Operating Officer 2. Theatre staff workforce plan in place to be delivered by March 2024. Executive lead: Chief Operating Officer 3. Elective hub from January 2024 at PRH (phase 1 and phase 2). Ongoing works for move of renal outpatient dialysis from PRH to Hollinswood House - expected ~~September~~ November 2023. Executive lead: Chief Operating Officer. 4. Develop and recruit to apprenticeship positions by October 2023. Use temporary bank staff along with inpatient booking staff to cover vacancies in the interim. Executive lead: Chief Operating Officer 5. Deputy Medical Director to support further clinical engagement to deliver outpatient transformation by September 2023. Lead Executive: Medical Director.	1. Training completed in July and August 2022 to increase the capacity of the POD (the new Radiology unit at RSH). Previously unable to open the POD fully due to workforce gaps, sickness, etc (open three days a week). Utilising insourcing capacity to staff the POD - opened 10 July 2023 - 7 days per week. 2. Recruited into vacancies but currently super-numerary. Risk to staff retention if we cannot recover elective activity quickly. Recruitment issues still exist at both sites (Q1), but recruitment events taking place. Revised workforce business case to retain staff via career progression structure - working towards it and have recruited to the roles. Utilising insourcing company to provide ten sessions of theatre staff for PRH. 3. Elective hub will be fully operational from January 2024 (23 trolleys and 4 theatres) 4. Unable to recruit to positions. Back out to advert. Using bank and agency to fill gaps ~~and have recruited to some apprenticeship positions.~~ Trying to recruit to apprenticeship positions but proving challenging due to the nature of the work. 5. Chief Operating Officer contacted Deputy Medical Director. Support is in place. Peer to peer support in place from other organisations with best practice pathways.			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.			**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: 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 Care 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). • Performance Review Meeting (PRM's) (2nd) Weekly System Key Performance Metrics Meeting (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 bed capacity is not expected to meet demand. 4. Winter schemes to mitigate the rise in demand for UEC. 5. Reconfiguration of some services for better healthcare management. **Gaps in assurance:** -	**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 December 2023. Executive lead: Chief Operating Officer and Director of People & OD. 2. A business case for the PRH ED (paeds) to be further reviewed and developed by end of ~~August 2023~~ April 2024. Executive lead: Chief Operating Officer. 3. Two modular wards to be in place from January 2024. Executive Lead: Chief Operating Officer. 4. Develop initial integrated system winter plan by end of September 2023. Executive lead: Chief Operating Officer. 5. (see 3, plus SaTH involvement in the ICS local care programme, e.g. virtual ward - see BAF risk 12).	1. Recruitment ongoing and in progress. 2. PRH business case is going through divisional governance structure for assurance and support, and then subsequent capital funding needs to be identified. 3. Work ongoing with Shropshire Community Trust (as modular wards to be run by the community trust). 4. **Action complete (Q2)**. To be received at December 2023 Board meeting. 5. Expanding the use of virtual wards in frailty, cardiology and respiratory; and outpatient antibiotic therapy (OPAT).			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 Hospital Transformation Programme	Service Delivery Our patients and community	**SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.**			**Finance & Performance Assurance Committee and HTP Sub-Committee**					
Risk opened: 1 April 2022			Matthew Neal										

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 at implementation in 2026/27 and further growth of 108 beds by 2031/32. **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) - SaTH have now submitted the draft outline business case (OBC) to NHSE and DHSC to further develop the options, on behalf of the local health system/Integrated Care System (ICS), for detailed regulatory review in Q1 of 2023/24 - Joint Investment Committee is planned in the summer of 2023. • System, Urgent and Emergency Care (UEC) Plan has been produced for 23/24 - 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 (currently under implementation); (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 (a range of outsourcing schemes will be utilised in 2023/24). • Development of the integrated ICS Workforce Plan. • SaTH/Shropshire Community Healthcare Trust provider collaborative in place from quarter 4, 2022/23, focused on Local Care Transformation Programme.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (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 Sub-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 3. Gap in alignment between Hospital Transformation Programme (HTP) and ICS Joint Forward Plan 4. Lack of system estates strategy referenced within BAF risks which could impact on full business case approval **Gaps in assurance:** 5. Personnel (HTP and Divisional), demand and capacity, dependency on system-wide programmes and governance to be expanded as part of ~~outline~~ full business case stage. 6. Need to ensure wider infrastructure is in place to enable the power requirements for our sites. 7. Need to ensure a positive planning application is achieved for the new buildings to be developed on our sites.	**Actions aligned to gaps:** 1. Develop the outline business case (OBC) and submit to NHSE by 4 May 2023, prior to national Joint Investment Committee Meeting. Executive lead: Director of Strategy & Partnerships. 2. Implementation of the elective surgery hub build. Executive lead: Chief Operating Officer. By end of 2023/24. 3. Incorporate alignment between HTP and ICS Joint Forward Plan - by end of quarter 1, 2023. Executive lead: Director of Strategy & Partnerships. 4. Include system estates strategy as appendix to the full business case under development and due by December 2023. Executive lead: Director of Delivery and Transformation, STW ICB. 5a. Continue recruitment process now that funding is confirmed, by Q1 2024. Executive lead: HTP Director. 5b. Review the demand and capacity as part of the full business case, with the engagement of the Divisions, by 1 December 2024. Executive lead: HTP Director. 5c. HTP Director to hold regular meetings with ICB Chief Executive and Director of Finance to determine details of their strategy and the impact on HTP, to ensure co-production, up to 1 December 2023. (The Director of Finance is also a core member of the HTP Programme Board.) Executive lead: HTP Director. 6. Providers to confirm that they can deliver the necessary infrastructure for the new hospital buildings. Executive lead: HTP Director, by ~~end of Summer~~ Autumn 2023. 7. Shropshire Council to validate planning application and Trust to be in receipt of planning approval by November 2023. Executive lead: HTP Director.	1. SaTH received approval of the Strategic Outline Case and support to move to the OBC stage on 26 August 2022. Draft OBC submitted as planned, 4 May 2023. On track for Joint Investment Committee (JIC) review of the HTP OBC in Summer 2023. The OBC was positively received at JIC on 3rd August 2023, but is subject to Treasury approval, the outcome of which is expected by end September 2023. 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 (PRH) was approved (with conditions). The second scheme of the Elective Surgical Hub at PRH was approved by national panel on 27 September 2022. The elective surgery hub build is underway at PRH site (Q1 2023). 3. HTP has been included in Shropshire Telford & Wrekin ICS Joint Forward plan (JFP) as one of the core programmes for the system and a priority. The JFP was approved at the ICB at end of June 2023, and has been published on the ICS website. **Action closed.** 4. Letter confirming that estates strategy will be in place has been received. The Estates Strategy is being written by Associate Director of Estates (owned by the Director of Finance) with a target date of completion by Mid October 2023. 5a. Substantive Director of HTP appointed and commenced 20 March 2023. Selection and appointment process of principal supply chain partner undertaken during Q1 2023/24, in accordance with national 'procure 23' framework. **Action closed.** 5b. As part of the full business case we are required to review the demand and capacity modelling, and this is underway. 5c. Meetings are taking place. HTP Director has been asked to sit on Local Care Transformation Board to ensure HTP aligns with local care transformation programmes. During the NHSE full business case submission, there will be a gateway 3 review of our governance processes and programme which will be rated. 6. Working with Infrastructure Partners such as National Grid to ensure that necessary infrastructure is in place within the wider network to ensure the new buildings can function. The energy supply risk has been added to Datix and accepted by the Director of Finance. The actions and mitigations associated are detailed and will be monitored through the HTP Governance architecture and Datix. 7. Planning has been submitted and work is ongoing with Shropshire Council and our wider neighbours to ensure that this progresses through Planning Committee. The planning consultation period remains live until 14th September. Active Travel England (ATE) have requested a deferral of the application, and a constructive meeting has been held with ATE to try to address their remaining concerns.			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 the Local Care programme, SaTH is a key member)	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 • Lack of cohesive approach to diabetes management **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 • Increased acute diabetes presentations.	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) • Via System reporting and increase has been seen in the number of patients stepping down from the virtual ward from SaTH, but not material enough at this stage to reduce the ongoing daily bed gap. • Daily reporting on use of Virtual Ward - number of patients that are stepped down onto ward (1st) • Weekly UEC assurance meeting (1st) • System Quality Risk Register and Diabetes Transformation Update reported to ICS Quality and Performance Committee - 22 March 2023. • Information now received from Shrop Comm (Q4 22/23) with regard to the number of referrals to be made to the virtual ward in order to realise the benefits in bed days.	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. We now have Virtual Ward Champions in SaTH and a video on the intranet explaining the virtual ward process. Clinical pathways signed off and in place for Virtual Ward. Daily reporting on use of Virtual Ward into SaTH. Q2: We are not seeing the level of referrals onto the virtual ward that we have for planning purposes within the operational plan (23/24), despite having the relevant actions in place.			9

Reference and risk title			Lead Executive	Link to Strategic Pillar	Risk appetite			Board Committee	Link to Strategic Objective (including Executive lead)				
BAF 13 (23/24): The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance			**Director of Governance**		SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.			**Audit & Risk Assurance Committee**					
				Our Governance									
Risk opened: 1 April 2023			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: • Trust Policy Framework requires review • Scolding (Independent) Review - Fit & Proper Persons • Poor processes and procedures • Culture • Governance improvement workload is high - started from a low base with embedded poor practices in some areas **Consequence:** • Lack of clear guidance for staff to follow and some out of date policies • Lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Serious incidents • Delay in completing internal audit recommendations • Potential ineffective committees, including late circulation of papers and breach of Standing Orders • Potential data breaches • Regulatory sanctions and/or fines	4	4	16	• Getting To Good (G2G) governance workstream • Trust Strategy • Board Assurance Framework (BAF) refreshed in 2022 • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and refreshed 2022 • Managing Conflicts of Interest Policy updated during 2022 and 2023 • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests available on the Trust's website • Terms of reference refreshed for all assurance committees of the Board during 2022/23 • Review of effectiveness of FPAC and QSAC committees June/July 2023 • Committee effectiveness session held with Board in January 2023 • Scolding Review action plan in place • DSPT action plan in place and cyber security exercises planned at local and ICS level	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit Committee and Board during 2022 (2nd) • BAF considered at each quarterly Board meeting (2nd) • Managing Conflicts of Interest Policy to Audit Committee during 2022 and 2023 (2nd) • Refreshed terms of reference considered at all Board committees during 2022/23 (2nd) • 2022/23 Annual Report to Board in June 2023 and published on Trust's website (2nd) • Auditor's Annual Report 22/23 published on Trust's website (3rd) • Annual General Meeting held in public (face to face) 30 August 2023 • Head of Internal Audit Opinion April 2023 providing Substantial Assurance that there is a good system of internal control (3rd) • Data Security and Protection Toolkit 2023 submitted (June) with 'approaching standards' outcome	4	3	12	**Gaps in control:** 1. Trust Policy Framework. 2. Lack of visibility of governance arrangements within the organisation. 3. Awareness of Conflicts of Interest policy within key decision making groups, impacting on Counter Fraud Authority standard attainment (currently 'amber' for this particular element). 4. Awareness of internal audit process. **Gaps in assurance:** 5. Reporting of the percentage compliance of decision making staff declaring their interests 6. Data Security & Protection Toolkit assurance	**Actions aligned to gaps:** 1. Review the Trust's policy framework via a project including governance, PMO, risk management and IT by December 2023. Lead Executive: Director of Governance. 2. Develop 'governance maps' to outline the groups/meetings in the Trust below Board committee level - by 30 September 2023. Lead Executive: Director of Governance. 3a. Deliver conflicts of interest awareness sessions with key decision making groups within the Trust by November 2023. Lead Executive: Director of Governance 3b Put in place reports to Divisions/departments detailing outstanding 'decision making' staff required to make declarations by September 2023. Lead Executive: Director of Governance. 4. Actively raise awareness with management leads of overdue internal audit recommendations and the importance of the internal audit process, by October 2023. Lead Executive: Director of Governance 5. Develop declarations of interest compliance reports to Audit & Risk Assurance Committee (following the introduction of declarations within ESR) by October 2023. Lead Executive: Director of Governance. 6. Deliver DSPT action plan by end of March 2024. Lead Executive: Director of Governance.	1. Phase one completed regarding scoping current processes. Policy framework currently under review, including current delegations of authority. 2. First draft completed 3a. Joint conflicts of interest and counter-fraud awareness session dates agreed with Finance and Procurement teams for October 2023. 3b. Regular reporting established July 2023. 4. Action completed (Q2). Awareness raised with executive directors, who are responsible for implementation of their actions. 5. First report received at 4 October 2023 Audit & Risk Assurance Committee meeting. 6. The Trust's current DSPT standards status at 30 June 2023 is 'approaching standards'. There are four areas of action within the action plan. Against which, work has already commenced.			3