The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 September 2024

Agenda item		138/24		
Report Title		**Board Assurance Framework – Draft Quarter 1, 2024/25**		
Executive Lead		Director of Governance – Anna Milanec		
Report Author		Head of Corporate Governance & Compliance – 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 - 30 July 2024 Finance & Performance Assurance Committee – 30 July 2024 Audit and Risk Assurance Committee – 2 September 2024		
Executive summary:		The Board Assurance Framework (BAF) content has been thoroughly refreshed for quarter 1 of 2024/25 by the executive risk owners and their relevant senior team members. This quarter, there are three proposed changes to current total risk scores as follows: BAF risk 5 reduction from 20 to 16 BAF risk 6 reduction from 16 to 12; and BAF risk 7a increase from 15 to 20. The 2024/25 BAF has been aligned to the Trust's strategic themes/objectives, along with the draft 2024/25 risk appetite statement and associated proposed risk upper tolerance levels.		
Recommendations to the Board:		The Board is asked to: a) Consider if the proposed changes to the BAF scores reflect the level of strategic risks within the organisation and if the risk scores are appropriate within the purview of the Board? b) Consider if there is evidence of successful management of the risks and if actions are being progressed in a timely manner? c) **Approve** the BAF for end of Q1 2024/25.		
Appendices:		**Appendix 1**: Board Assurance Framework (draft) - Quarter 1		

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 1 was undertaken during mid-June 2024 to mid-July 2024.

1.3 In particular, the Board's attention is drawn to the risks within the purview of the Board, i.e., BAF risks 7a and 13

1.4 The Board held a risk/BAF seminar on 25 April 2024 where it considered risk appetite and risk tolerance levels. The draft proposed risk appetite and upper risk tolerance levels have been added to the Q1 BAF. The new upper risk tolerance levels replace the previous risk 'target'.

1.5 This quarter, the BAF has also been aligned to the Trust's strategic themes/objectives, with support from the Associate Director of Strategy and Partnership.

2.0 Significant changes to the BAF during quarter 1 2024/25

2.1 The draft BAF can be found within **Appendix 1.** New narrative since the previous quarter's BAF is shown in blue text.

2.2 It was proposed in quarter 1 to reduce the current total risk score of BAF risk 5 (*The Trust does not operate within its available resources, leading to financial instability and continued regulatory action*) from 20 to 16 due to the funding agreement for the 2024/25 financial year.

- Members of the Audit and Risk Assurance Committee (ARAC) on 2 September were not in full agreement with the proposal to reduce the current risk score and indicated that they would struggle to support the proposal for the reduction.

2.3 It was proposed to reduce the current total risk score of BAF risk 6 (*Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose*) from 16 to 12 due to action plans in place and enhanced risk monitoring across every sector, reported at Performance Review Meeting's and internally.

- On 2 September, members of the ARAC proposed that the score of 16 be retained.

2.4 It is proposed to increase the current total risk score of BAF risk 7a (*Failure to maintain effective cyber defenses impacts on the delivery of patient care, security of data and Trust reputation*) from 15 to 20 due to the current cyber risk environment.

- Members of the Finance & Performance Assurance Committee, when considering this risk, felt that the score should remain at 15.

- On 2 September, members of the ARAC were unsure whether the score should increase or not, with a question as to how things were now different from the previous quarter.

- At the same meeting of ARAC, a Cyber Security Progress Report was presented to the Committee and confirmed that the corporate risk register contains risks for "Emerging and existing cyber security threats especially

due current political unrest" (risk ID 499) and "Unsupported Server Operating Systems" (risk ID 496), both of which feed into the BAF risk 7a.

- An outstanding action against risk 496 to implement a Security Operations Centre and Security Incident and Event Management (SIEM) solution was identified as part of an Integrated Care System (ICS) wide 'levelling up' agenda which would mean a SaTH investment of £100K.

2.5 The lead committee for BAF risk 11 is proposed to be changed from FPAC and HTP sub-committee to HTP Assurance Committee.

- On 2 September, members of the ARAC indicated their support for the change.

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 viewed within the draft BAF (Appendix 1).Based on the draft current total risk scores for quarter 4, there are two top risks with a risk score of 20; six risks with a current total risk score of 16; one with a score of 15 and five with a score of 12, as indicated within the BAF summary page.

3.2 The two top risks, with a current total risk score of 20, are shown below. Since quarter 4 of 2023/24, BAF risk 5 is proposed to be removed from these top risks scoring 20 following a proposed decrease in current total risk score in quarter 4 from 20 to 16.

The two top scoring BAF risks based on draft current total risk scores at quarter 1:

No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 1, 2024-25	Change in risk score since quarter 4 2023-24
BAF 7a	The inability to implement modern digital systems impacts upon the delivery of patient care	Audit & Risk Assurance Committee	5x4 = 20	↑ Increase from 15 to 20
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

3.3 Being aware of the proposed top scoring risks 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.
- The comparative scoring of all risks.

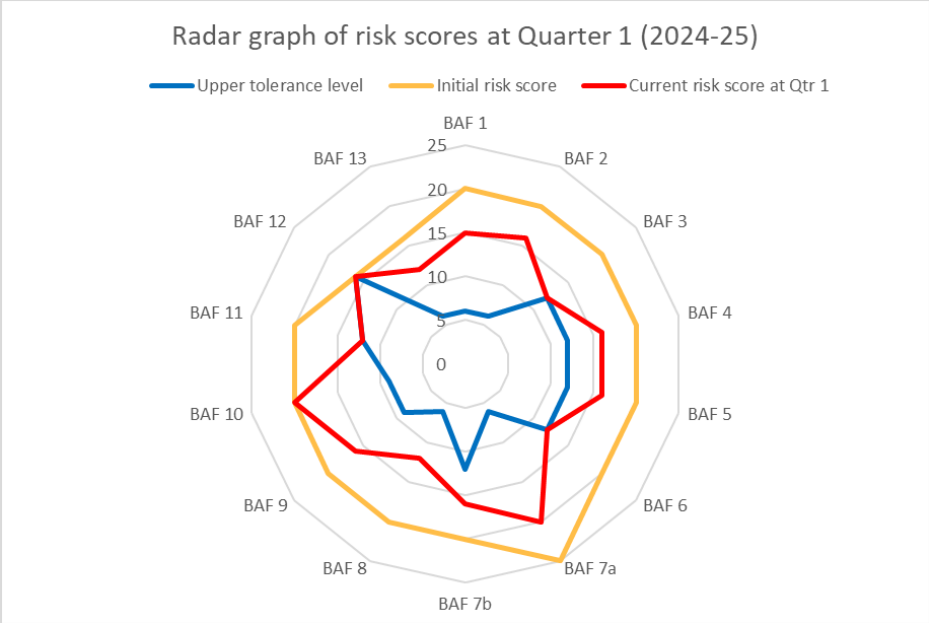
The BAF summary page indicates the scores for each risk which includes other extreme risks scored at 15 or above.

4.0 Visual representation of risk scores

4.1 The radar graph within the BAF (below) provides a visual representation of risk scores, including the proposed upper tolerance level of the risk, as per the draft 24/25 risk appetite statement. It is intended that this will assist the Committee/Board to:

- identify the gap between the risk upper tolerance level 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., BAF risks 10 and 12, and to consider if the controls are adequate for these risks or if further action and assurance is required.
- assist to continue to reflect on the upper tolerance levels for risks and whether these remain appropriate and achievable.

4.2 It is noted that for BAF risks 3, 6, 11 and 12, the current total risk score is the same as the proposed upper tolerance level. All other BAF risks remain above their upper tolerance levels.



5.0 Recommendations

5.1 The Board is asked to:

a) Consider if the proposed changes to the BAF scores reflect the level of strategic risks within the organisation and if the risk scores are appropriate within the purview of the Board?

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

c) **Approve** the BAF and scores for end of Q1 2024/25.

DB / AM 3rd September 2024

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework (BAF) 2024/25 - draft quarter 1 (April - June 2024)

(Updated June/July 2024 - Version 1.1)

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

Board Assurance Framework 2024/25 - Summary

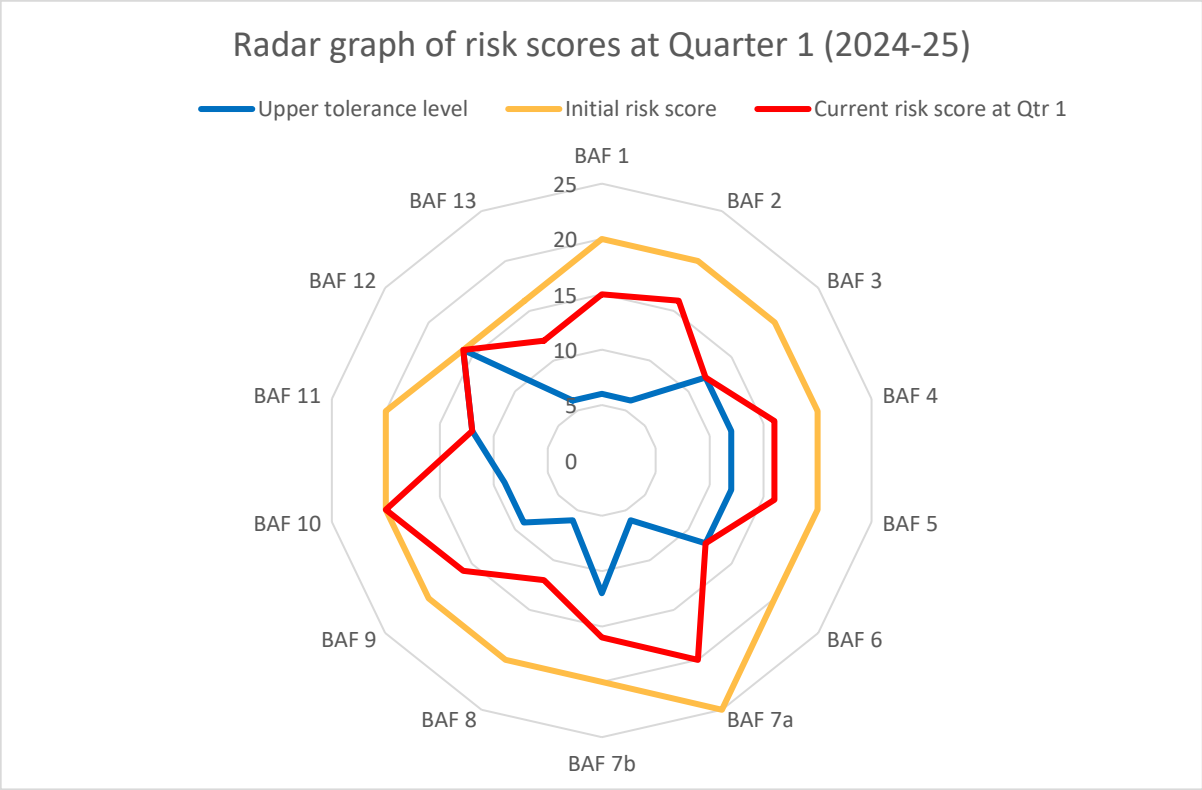
The Shrewsbury and Telford Hospital NHS Trust

										Current total risk score:	
Board Assurance Framework 2024/25 - Summary at Quarter 1 (April to June)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)***	**Lead Executive**	**Lead Committee**	**Quarter 1 (2023-24)**	**Quarter 2 (2023-24)**	**Quarter 3 (2023-24)**	**Quarter 4 (2023-24)**	**Quarter 1 (2024-25)**	**Change in current risk score between Q4 and Q1, plus any further comments**
Ref:	**Risk title:**											
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	5x4 = 20	6 (minimal)	Medical Director /Director of Nursing	Quality & Safety Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	↔ No change.
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	5x4 = 20	6 (minimal)	Dir of Nursing/ Medical Director	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Director of People & OD	People & OD Assurance Committee	4x4 = 16	4x4 = 16	4x3=12	4x3=12	4x3=12	↔ No change
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Director of People & OD	People & OD Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	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	Make our organisation more sustainable.	4x5 = 20	12 (open)	Director of Finance	Finance & Performance Assurance Committee	4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20	4x4 = 16	↓ Current total risk score has reduced from 20 to 16 due to the funding agreement for the 2024/25 financial year.
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	4x5 = 20	12 (open)	Assistant CEO	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x3=12	↓ Current total risk score reduced from 16 to 12 due to action plans in place and enhanced risk monitoring across every sector, reported at PRM's and internally.
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	5x5 = 25	6 (minimal)	Director of Strategy & Partnerships	Audit and Risk Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x4 = 20	↑ Increase in current total risk score from 15 to 20 due to current cyber risk environment.

Board Assurance Framework 2024/25 - Summary

										Current total risk score:	
Board Assurance Framework 2024/25 - Summary at Quarter 1 (April to June)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)***	**Lead Executive**	**Lead Committee**	**Quarter 1 (2023-24)**	**Quarter 2 (2023-24)**	**Quarter 3 (2023-24)**	**Quarter 4 (2023-24)**	**Quarter 1 (2024-25)**	**Change in current risk score between Q4 and Q1, plus any further comments**
Ref:	**Risk title:**											
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	4x5 = 20	12 (open)	Director of Strategy & Partnerships	Finance & Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change.
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x5 = 20	6 (minimal)	Director of Nursing	Quality & Safety Assurance Committee	4x3 = 12	4x3 = 12	4x3 = 12	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	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x5 = 20	9 (cautious)	Chief Operating Officer	Finance & Performance and Quality & Safety Assurance Committees	4x4 = 16	4x4 = 16	4x5 = 20	4x4 = 16	4x4 = 16	↔ No change. In order for SaTH to deliver and maintain a reduction in the waiting list size and waiting times there is a requirement for the next 12-18 months for insourcing capacity and, therefore, we need to plan for this appropriately. At present the score remains at 16, but will be reviewed again in quarter 2.
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x5 = 20	9 (cautious)	Chief Operating Officer	Finance & Performance and 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.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	5x4 = 20	12 (open)	Director of Hospitals Transformation Programme	Hospitals Transformation Programme Assurance Committee	4x4 = 16	4x4 = 16	4x3 = 12	4x3 = 12	4x3 = 12	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led by the ICS and ICP.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x4 = 16	16 (eager)	Chief Operating Officer and Director of Strategy & Partnerships	Quality & Safety Assurance Committee	4x3 = 12	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 13	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	4x4 = 16	6 (minimal)	Director of Governance	Audit and Risk Assurance Committee	4x3 = 12	4x3 = 12	4x3 = 12	4x3 = 12	4x3 = 12	↔ No change

Visual representation of risk scores



Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite						
BAF 1: **If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will be unacceptable.**			**Medical Director/ Director of Nursing**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	**SaTH has a MINIMAL risk appetite for risks that may compromise safety and the achievement of better outcomes and experience for patients. We are willing to consider actions which present a low risk to quality and safety priorities and objectives. We recognise, however, that we may have to tolerate a higher impact within the patient experience domain and greater levels of escalation.**			**Quality & Safety Assurance Committee**				
Risk opened: risk content refreshed 1 April 2023 (previous risk within 2021/22)			John Jones/ 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	Upper tolerance level
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 in specific areas (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 • 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 • 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 • Rapid review meetings/ RALIG both in place • Quality governance framework within Divisions • Exemplar programme (ward accreditation) • Monthly Nursing Metrics • Daily incident communications (Datix) • 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 • Patient Safety Specialist in post • 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 • Key Performance Metrics Monitoring Meeting (weekly) • Hospital Full Policy launched December 2023	**Reported to Board, committees and elsewhere:** Non-Executive led assurance committees: • Quality & Safety 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 May 2024 provides assurance that improvements are being made across the Trust (3rd) • Quality Account to QSAC/Board (2nd) • Incidents 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); 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; Nutrition and Hydration; Palliative End of Life Care Steering Group; 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) • Quarterly FTSU updates to Board (2nd) • External Peer reviews in neonatal, trauma and critical care in Q3 (3rd). Initial feedback received from external neonatal review; full report due. Action plan being developed for initial recommendations. Action plans for both trauma and critical care have been submitted to peer review teams. Progress in relation to action plans will be sought through PRM's. • ICB quality peer review in ED - April (3rd) • Q4: Reset and Review meeting - national maternity team - awaiting results (3rd) • Internal audit reviews (MIAA) 23/24: Infection Control - *Substantial assurance* ; Mortality Governance - *Substantial assurance;* Duty of Candour - *Substantial assurance* ; Quality Spot Checks - Limited assurance (3rd)	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. theatres, band 6 nurses in ED, endoscopy, doctors within critical care, care of the elderly, emergency medicine. 2. A number of patients with no criteria to reside and lack of alternatives to hospital admission, 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) and development and roll-out of Patient Safety Strategy. 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:**	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 (for nursing, midwifery and AHP) and Simon Balderstone. During 2023 and 2024. 2a. See BAF risk 10. 2b. *See BAF risk 10.* 3. Electronic Patient Record planned by end of 2025. New patient administration system (PAS) to be in place as per agreed implementation plan (see BAF risk 7b). Executive lead: Director of Strategy & Partnerships. 4. Develop a three year Patient Safety Strategy by Q2 2024 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead Director of Nursing. In addition to support the strategy: 5. Hold ward mangers away day in July to scope out development needs over the year (including nursing, midwives and AHP's) by Q2. Executive lead: Director of Nursing. 6. Introduce refreshed Policy for Policies and Policy Approval Group in Q2 24/25. Executive Lead: Director of Governance (as per BAF risk 13). 7. Development of the framework and to report to QOC in Q3 24/25. Executive Lead: Executive Medical Director	1b. All band 5 vacancies in ED and ward areas recruited to, but there will be requirements for specialist areas including theatres, endoscopy and ED Band 6's. 3. Digital roadmap being followed with plans for new patient administration system (PAS), as per agreed implementation plan. See action 3 update within BAF risk 7b. Q4: EPR phase one (Care Flow) implementation went live on 19 April 2024. 4 In progress. Working to align the Patient Safety Strategy to the Quality Strategy. Once complete, will go via Quality Operational Committee for approval. Anticipate June 2024. 5. At Q4: planning an away day session with ward managers in the first instance in July 2024 to scope what they think are their requirements alongside what is needed at organisational level. Action remains ongoing. 6. Policy Approval Group meeting dates now established and commencing in Q2, 24/25. 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. A further meeting was scheduled for January 2024. Q4: Meeting to be held 23 April 2024 to consider revised terms of reference for the meeting and its purpose.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 2: The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.			**Director of Nursing/ Medical Director**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	**SaTH has a MINIMAL risk appetite for risks that may compromise safety and the achievement of better outcomes and experience for patients. We are willing to consider actions which present a low risk to quality and safety priorities and objectives. We recognise, however, that we may have to tolerate a higher impact within the patient experience domain and greater levels of escalation.**			**Quality & Safety Assurance Committee**						
Risk opened: risk content fully revised Q2, 2023/24 (previous risk within 2021/22)			Hayley Flavell/ John Jones											

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	Upper tolerance level
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 • 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 quarter Q1: FTSU workers at 91.11%, FTSU managers at 80.94% and senior leaders at 65%. • 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 (was undertaken Oct to Nov 2023) • PSIRF Plan and Policy • 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. • Board FTSU self-reflection tool: Board development session held 1 November 2023 • Review of all mandatory training has begun and SEMTRAG (SaTH Education Mandatory Training Group) established in Q4 - February • Two Family Liaison Officer posts put in place during Q4, who will feedback following learning from incidents	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) Patient Experience & Complaints Report to QSAC - quarterly (2nd) • ARAC - Audit & Risk Assurance Committee (2nd) - bi-annual FTSU reports • 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) • Update to Operational People Group on retention, featured Improvement Hub progress (Nov 2023) (2nd) • FTSU priorities shared and agreed at February 2024 Board meeting (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 having confidence and 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 6. Unprecedented continued overcrowding in ED's and its impact on normal culture **Gaps in assurance:** 7. Lack of information reported on longest complaints outstanding by division.	**Actions aligned to gaps:** 1a. Deliver the Getting to Good (G2G) Plans for each of the NHS Impact five continuous improvement components during 2024/25. Executive lead: Director of People & OD. 1b. Embedding the Just Culture Framework and linking to workforce policies and procedures, during 2024-2026. Executive lead: Director of Nursing and Director of People & OD. 2. Develop a three year Patient Safety Strategy by Q2 2024/25. 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 3c. Produce Improvement Hub Annual Report by May 2024. Executive Lead: Director of People & OD. 3d. Learning from patient complaints and reduction in common themes - ongoing. 4. Review, refresh and implementation of new ambassador network by December 2024. Executive Lead: Director of Governance. 5. Appoint Clinical Lead for Improvement during 24/25. Executive lead: Medical Director 6a. Deliver the actions identified in the culture work stream within UECTAC transformation programme during 24/25. 6b. UEC Board to deliver agreed 24/25 milestones. 7. Introduce reporting as part of patient experience and complaints report on the longest outstanding complaints by division, by end of Q2.	1a. Reporting through Getting To Good Group on a monthly basis. 1b. Improvement work has commenced looking at decision making groups, investigation time frames and further training needs. 2. Patient Safety Strategy in draft form and requires further consultation. 3a. Conference delivered May 2024. **Action closed Q1.** 3b. Staff Survey went live Oct-Nov 2023 with results published 7 March 2024. 45% response rate received to Staff Survey. Divisional plans due to be reported to PODAC in April. Divisional briefings being delivered March/April 2024. **Action closed Q1.** 3c. Improvement Hub Annual Report completed. **Action closed Q1.** 3d. Ongoing review of complaints and actions. 4. 5. Q1: Awaiting confirmation of budget.			6

Reference and risk title			Lead Executive	Link to strategic themes	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**	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.**			**People & OD Assurance Committee**						
Risk opened: risk within 2021/22			Rhia Boyode (RB)											

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	Upper tolerance level
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 • 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 • Recruitment control processes in place to review current resources and skill mix **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 in medical and dental groups. • High levels of sickness and turnover. • Industrial action • Poor patient experience and outcomes. • Adverse publicity and/or reputational damage. • May lead to the financial unsustainability of some services. • Needing to reform our services	5	4	20	• People governance arrangements in place including Strategic People 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 SPG/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 • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Continued use of new roles such as 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 • Vacancy and spending control panel	**Reported to Board, committees and elsewhere:** • Reports to People & OD Assurance Committee (PODAC) and Strategic People and Educational Group (SPG) (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 2024 (2nd) • Equality, Diversity & Inclusion Strategy approved by Board 2020 (2nd) • Quarterly/monthly People Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at SPG (2nd) • Financial Governance Group - weekly (2nd) • Executive dashboard on agency expenditure - weekly (1st) • MIAA (internal audit): Staff Wellbeing & Engagement review to ARAC - Substantial assurance . • MIAA Rota Review Assignment Report to ARAC - limited assurance (3rd)	4	3	12	**Gaps in control:** 1. Systematic process throughout the Trust to support succession planning. 2. Embedded processes for medium- and long-term workforce planning mechanisms with links to transformation/Hospital Transformation Programme. 3. Recognition schemes. 4. Managing Working Time Directive breaches and management of rosters for medical staff. 5. Ongoing retention initiatives. 6. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS People Plan. 7. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. **Gaps in assurance:** 8. Employee relations practice in relation to harassment and discrimination.	**Actions aligned to gaps:** Executive Lead for actions: Director of People and Organisation Development. 1. To work with system colleagues to develop a system approach to talent management - during 24/25 and 25/26. 2. Harmonise key workforce datasets with system partners to support cohesive system level reporting and workforce planning during 24/25 and 25/26 3. Developing monthly recognition scheme delivered alongside our annual recognition programme during 24/25. 4. Visibility of all rosters and review consultant rosters during 24/25 and 25/26. 5. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 24/25. 6. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans by March 2025. 7a. 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 2025. 7b. Board members should demonstrate how organisational data and lived experience have been used to improve culture, by March 2025. 7c. 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 2025. 8. Ensuring policies and procedures in relation to employment are continually reviewed during 24/25.	1. As a system, initial conversations to support the High Potential leadership scheme and roll-out Galvanise leadership programme 2. As a system we have developed a systemwide dashboard on workforce planning. 3. - 4. Until one roster system is implemented, the full benefits of having doctor working hour visibility will not be realised. 5. Q1: Stay conversation framework is in development. Train the trainer for wellbeing conversations completed. 6. Looking to support Divisions to undertake the diagnostic tool, as risk in divisional capacity available to do this. 7a Objectives in place for current year. 7b Ongoing work. EDI Board development session held on 27 June 2024. 7c. Gender Pay Gap report approved by Board in February 2024. Annual EDI report received at March 2024 Board 8. Q1: Improvement work has commenced looking at decision making groups, investigation time frames and further training needs.	3	2	12

Reference and risk title			Lead Executive	Link to strategic themes	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**	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.**			**People & OD Assurance Committee**					
Risk opened: risk within 2021/22			Rhia Boyode										

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	Upper tolerance level
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 • Recruitment control processes in place to review current resources and skill mix **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 • Reforming our services	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 • Vacancy and spending control panel	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee (2nd) • Strategic People Group (SPG), 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) • MIAA (internal audit) Staff Wellbeing & Engagement review to ARAC - substantial assurance (3rd) • MIAA Rota Review Assignment Report to ARAC - limited assurance (3rd)	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. Developing workforce supply routes 3. New ways of working 4. Systematic process throughout the Trust to support succession planning. 5. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 6. 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 during 24/25. 2. Further strengthen our widening participation approach during 24/25. 3a. Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 24/25 through to 2030. 3b. Deploy Manager Self Service within the Electronic Staff Record by 25/26. 4. To work with system colleagues to develop a system approach to talent management - during 24/25 and 25/26. 5. 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. 6. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 24/25 and 25/26.	1. Q1: Stay conversation framework is in development. Train the trainer for wellbeing conversations completed. 2. In June 2024, we hosted a teacher encounters session. Our Project Search interns are graduating this month after completing a 12 month intern programme. 3a. Implemented ESR Go for medic on duty which provides a mechanism for automating staff contractual changes and taking information processed on ESR and updating Health Roster. ESR Business Intelligence alerting functionality being developed. Currently exploring robotic process automation opportunities and investment levels required. 3b. A trial of team based rostering has been launched on ward 23. 4. As a system, initial conversations to support the High Potential leadership scheme and roll-out Galvanise leadership programme 5. WRES and WDES data for 2024 has been completed. Annual report due to Board in September 2024. EDI Champions training completed and ongoing support network in place. 6. -			12

Reference and risk title			Lead Executive	Link to strategic themes	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**	Make our organisation more sustainable	**SaTH is OPEN to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and potential regulatory action to tolerable levels.***			**Finance & Performance Assurance Committee**						
Risk opened: risk within 2021/22			Helen Troalen		**(*Note: In all circumstances, the Trust has no appetite for fraud and/or other financial crime risk)**									

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	Upper tolerance level
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 • 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 National 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 2024/25 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing junior doctors rotas to ensure compliance • System-wide vacancy control process. • Non-pay triple lock process to review mostly all non-pay expenditure over £10k	**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) - Substantial assurance • 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) • Interim Budget setting paper for 24/25 to FPAC and Board 26/03/24 (2nd), with final one due in July 2024.	4	4	16	**Gaps in control:** 1. Divisions recognise their financial responsibilities and engage well however, financial management, effective sustainability and efficiency planning compete with other high profile priorities across the Trust. 2. Identification and delivery of a £44.7 million cost improvement programme and adherence to cost control policies and processes 3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 4. 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. 5. Understanding how SaTH 5 year plan feeds into health system financial plan. **Gaps in assurance:** -	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 25/26 by Dec 2024. Executive lead: Director of Finance. 1b. Staff reduction targets with a monthly recruitment ceiling issued to divisions to achieve agreed exiting whole time plan by March 2025. Executive Leads: Chief Operating Officer/Director of People & OD/individual executives. 1c Monthly Operational Performance Oversight Group to be chaired by Director of finance with COO as Vice Chair to review financial and workforce performance with a regime of escalation for divisions not delivering to plan - ongoing. Lead Executive: Director of Finance. 2a. £37.7 million was identified by the time of the final operating plan submission on 12 June 2024, with only the £7 million stretch remaining unidentified. The priority is to de-risk and deliver the initial £37.7m, with attention turning to the remaining £7m after that - time scale TBC. Executive lead: Director of Finance. 2b. Set up an internal multi-disciplinary financial recovery task force with membership mirroring divisional leadership teams - by mid-July. Executive lead: Director of Finance 2c. Identify and recruit a financial improvement director by mid-July 2024. Executive lead: CEO 3a. Alignment of budgets between finance and HR systems to take place on a manual basis, with an initial focus on nursing ward areas and non-consultant medical staffing - September 2024. Executive lead: Director of Finance and Director of People and OD. 3b. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - September 2024. Executive lead: Director of Finance and Director of People and OD. 4a. Introduce OPOG escalation measures internally to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact - ongoing. Executive lead: Director of Finance/Chief Operating Officer. 4b. System-wide management of escalation capacity to ensure the most cost effective service provision - timescale TBC. Executive lead: Director of Finance. 5. Sath have completed a medium term financial plan as part of the HTP business case, system-wide medium term financial plan required which is linked to a system-wide demand and capacity model - by Q2. Executive lead: Director of Finance	1c Operational Performance Oversight Group in place, with one division in escalation at the end of month 2. 5. Work commissioned to develop a system-wide demand and capacity model has been completed, model to be updated following the final 24/25 planning submission which was on 12/6/24.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 6: Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose			**Assistant CEO**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**Recognising the current position with the Trust's estate, SaTH is OPEN to transforming its buildings/infrastructure to support better outcomes and experience for our patients and public. We will consider benefits and solutions which meet organisational requirements and ensure a safe environment.**			**Finance & Performance Assurance Committee**					
Risk opened: risk within 2021/22			Inese Robotham										

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	Upper tolerance level
Cause: • Older buildings built with now outdated regulatory requirements • Restricted physical environment, unable to meet current capacity requirements • Backlog maintenance issues due to limited capital • Residual gaps in fire safety action plan • 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 possible • Adverse publicity and reputational damage possible • Potential poor working conditions and environment affecting staff health, experience and engagement - increased sickness absence and recruitment.	**4**	**5**	**20**	• Board-approved (limited) Capital Programme including backlog maintenance plan and medical equipment budget in place eliminating all high risk backlog on a yearly basis. • Capacity & demand led capital programmes, aligned to Hospital Transformation Programme. • Capital Estates Plan 2021-2026 in place. • Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure. • 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) • Annual 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 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). • Authorising Engineer's Annual Fire Safety Audit 2023 (3rd) - presented to Director of Finance and Director of Estates Oct 2023 and action plan presented to the Board (private). • Independent structural engineers' review of RAAC (3rd) - Q3. Along with completion of mitigations in these non-clinical areas. • Performance Review Meetings (PRM's) bi-monthly.	**4**	**3**	**12**	**Gaps in control:** 1. Energy infrastructure at its limit on the site 2. Lack of up-to-date Estates Strategy. 3. Awaiting confirmation of RAAC funding to enable long-term remedial works. **Gaps in assurance:** -	**Actions aligned to gaps:** 1a. Utilise Salix funding for replacement infrastructure and choose supplier by July 2024, and look for additional external funding opportunities - ongoing. Executive lead: Assistant CEO. 1b. Internal full business case to be developed and presented to the Board by September 2024. Executive lead: Assistant CEO 2. Develop Estates Strategy by October 2024. Executive lead: Assistant CEO. 3. Proposal submitted to NHSE. Director of Estates regularly attends NHSE RAAC Board for update. Executive lead: Assistant CEO.	1a. Tender evaluations underway.			**12**

Reference and risk title			Lead Executive	Link to strategic themes	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**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**Whilst digital innovation will transform systems to support better outcomes, SaTH has a MINIMAL risk appetite in relation to cyber security and information governance compliance due to the impact on our patients and colleagues. Risk of loss or damage to information will be minimised through stringent security measures and business continuity planning.**			**Audit and Risk Assurance Committee**					
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	Upper tolerance level
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest • Increasing prevalence of threats globally • Funding constraints to invest in digital tools to improve cyber security **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 • Reinforces the need for dedicated resource and continued review of the capacity and capability required.	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 • Multi Factor Authentication (MFA) compliance for NHS mail	**Reported to Board, committees and elsewhere:** • Information Governance Committee - due to meet 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) • Dedicated monthly risk review meeting (1st) • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Cyber update report to 6 December 2023 Audit & Risk Assurance Committee meeting (2nd) • Internal audit (MIAA) of the Trust's DSPT self assessment - Substantial assurance (3rd) • Internal audit against the 10 National Data Guardian Standards - Moderate assurance (3rd)	5	4	20	**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. 4. Funding constraints. **Gaps in assurance:** 5. 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 - ongoing, funding dependent. Executive lead: Executive Lead: Director of Strategy & Partnerships 2. Continue our work as a health system partner during 23-24 and 24/25 as part of the work programme for the ICS Digital Delivery Group. 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by Q3 24/25. Executive Lead: Director of Strategy & Partnerships 4a. Re-prioritisation of internal digital capital funding during 2024/25. 4b. Continue to explore external funding opportunities during 24/25. 5. Develop/support medical device security report by Q2 2024/25. Executive Lead: Director of Strategy & Partnerships, supported by Assistant CEO	1. Update report on cyber position provided to Audit & Risk Assurance Committee (ARAC) Q3 (December). Risk mitigations plans are in place and compliance continues to evolve and be kept up to date in line with national guidance. Some plans require prioritised and costed way forward - which may require some resolution in 2024/25, funding dependant. 2. In work programme for 2024/25 for the Digital Delivery Group. 3. Content and format of strategy under development. Now expected end of Q3 2024/25 (which will take account of recently announced national changes to DSPT and cyber security compliance). External expertise commissioned to produce the final strategy document. 4. - 5. Q1: Updated report completed in June 2024. Validation of findings is in progress. Medical Device Security Working Group to be established to follow up on relevant actions.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 7b: The inability to implement modern digital systems impacts upon the delivery of patient care			**Director of Strategy & Partnerships**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**SaTH is OPEN to transform its digital systems to support better outcomes and experience for our patients and public. New technologies are viewed as a key enabler of operational delivery, productivity and efficiency (including clinical) following thorough assessment and testing.**			**Finance & Performance Assurance Committee**					
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	Upper tolerance level
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 • Prescribing and Medicines Administration (EPMA - electronic prescribing and medicines administration) system required. • 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 • Continuing national funding • Trust's Data Warehouse requires redevelopment and resourcing. • Reduction in digital capital allocation (national, regional and local). **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 - Operational Readiness Groups which feeds into appropriate Programme Board. Digital Oversight Group 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 • Chief Clinical Information Officer/Clinical Safety Officer in place along with Clinical Safety Committee (safety of software and reducing hazards for patient safety) • Chief Nursing Information Officer in place • Digital Nurses in place - temporarily • Director of Digital Transformation/Lead in place - at SaTH • Head of Digital Innovation & Transformation in place within the ICS • Digital Design Authority Group meet frequently to review the design for systems and sign off to ensure fit for purpose • Capital funding awarded and business case developed for order communications • Digital communications lead in place.	**Reported to Board, committees and elsewhere:** • Weekly highlight reports for areas of escalation, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Digital Oversight Group (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 Digital Oversight Group and receives monthly update (3rd) • Report to STW ICS Digital Delivery Committee with system updates to the ICB Strategy Committee (2nd) • Getting To Good (G2G) digital transformation workstream milestones reported to Board (2nd) • Daily Standup meetings, where appropriate (1st) • External assurance review by NHSE Digital System Support took place in January/February 2024 (3rd) - amber status (*successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun*). • Continued to hold NHSE Digital Systems Support Meetings for post-EPR go-live assurance (3rd).	4	4	16	**Gaps in control:** 1. Requirement for key roles in the digital programme - still working with agencies and Procurement for the remainder of the programmes to fill posts. 2. Capacity within wider trust teams for digital system implementations. 3. EPMA, Badgernet neonatal and several other digital initiatives do not have a source of funding. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Work with agencies and procurement to appoint into vacant digital positions as they arise during 2024-25. Executive lead: Director of Strategy & Partnerships 2a.A review of all digital initiatives and projects has been undertaken and continues to be reviewed during 24/25, aligned to the prioritisation of the service development capital allocation. 2b. The framework for the requirement for SRO, operational lead and clinical lead for each digital project has been described for 2024/25 and work is to be undertaken to review this with Divisions in 24/25. Executive lead: Director of Strategy & Partnerships. 3. Ongoing discussions with NHSE Regional Digital Team to explore external funding opportunities during 24/25. Executive Lead: Director of Strategy and Partnerships.	1. Digital positions continue to be appointed to, but we continue to have high turnover rates which reflects the current market position. 2a.Q1: Fortnightly review of the digital programme through the Digital Design Authority and monthly update to SLC. 2b. Q1: In progress. 3. Q1: Additional external funding has been secured for Laboratory Information Management System (LIMS). Divisions have prioritised their capital requests and gaps remain.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 8: The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.			**Director of Nursing**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH has a MINIMAL appetite to compromise legal and regulatory standards. We are only prepared to accept the possibility of very limited deviation from compliance during exceptional circumstances.**			**Quality & Safety Assurance Committee**					
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	Upper tolerance level
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 2024/25 the Trust has five Section 31 conditions in place	4	5	20	• Getting To Good (G2G) workstream: Quality & Regulatory Compliance • 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 • Palliative and End of Life Steering Group • 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 • CQC inspection report published May 2024 (3rd) • Current regional Insight visit for first Ockenden Report which focused on immediate and essential actions.	**Reported to Board, committees and elsewhere:** • Reports received monthly at Quality Operational Committee (QOC) (2nd) • Quality & Safety Assurance Committee (QSAC) reports received (bi-monthly) and monthly via AAAA report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions - 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 (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 March 2023 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). • External Peer reviews in neonatal, trauma and critical care in Q3 (see BAF risk 1) • CQC inspection undertaken on 10th and 11th October 2023, with Well Led undertaken 14th and 15th November - report due. • Internal audit reviews (MIAA) 23/24: Infection Control - Substantial assurance; Mortality Governance - Substantial assurance; Duty of Candour - Substantial assurance (3rd).	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. 79 Must and should do actions from CQC Report from May 2024 **Gaps in assurance:**	**Actions aligned to gaps:** 1. System leadership required. 2. Deliver CQC action plan during 24/25	1. The Trust is working with the ICS. A Midland Partnership Foundation Trust and SaTH meeting was held in June 2024 for new ways of working for children and young people with mental health. Children and Young People mental health summit occurred in September 2023 - continue to await next steps. 2. Agreed governance through transformation programme and G2G programme and ICB assurance to be agreed.			6

Reference and risk title			Lead Executive	Link to strategic themes	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**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is CAUTIOUS and prefers not to take risks to the achievement of internal and external performance standards where there is likely to be adverse consequences.**			**FPAC (financial impacts) and QSAC (patient/ quality/ safety related)**					
Risk opened: risk within 2021/22			Sara Biffen										

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	Upper tolerance level
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 • Outpatient Transformation Programme	**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 Committee reporting monthly (3rd) • Elective Recovery Board - Midland NHSE (3rd) • Weekly assurance meeting - 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 - 65 week recovery trajectory to FPAC and 52 week trajectory for children and young people (2nd) • DMO1 (diagnostics)recovery trajectory to FPAC (2nd) • Weekly UEC assurance meeting (1st) • MIAA (internal audit) Waiting List Management Report Q4 23/24 - High assurance (3rd).	4	4	16	**Gaps in control:** 1. Lack of resilient 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 3. Inadequate bed stock to maintain elective activity on both sites 4. Outpatient transformation standards still not being fully achieved **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Continue with year two of our Radiology workforce plan which includes undertaking recruitment including international recruitment; recruiting to support roles; continuing to develop the radiology workforce, using apprenticeships. 2. Ongoing recruitment and retention of Theatre staff by March 2025. Executive lead: Chief Operating Officer 3. Work is ongoing to provide an elective orthopaedic ward on the PRH site by 1 July 2024 following the closure of ward 5 due to inadequate air flow on the ward. Executive lead: Chief Operating Officer. 4. Deputy Medical Director to support the outpatient transformation clinical lead and divisional clinical leads to continue to implement outpatient transformation approaches including patient initiated follow up and remote monitoring by March 2025. Lead Executive: Chief Operating Officer.	1. Ongoing work in place as part of our workforce plan. 2. Theatres recruitment remains ongoing at Q1. Elective Hub opened on 10 June 2024 which should assist with theatre staff recruitment and retention. 3. Work is ongoing on the PRH site to reconfigure services to accommodate and elective orthopaedic ward. 4. A gap analysis has been undertaken against *Going Further Faster* guidance and actions are included within the outpatient transformation plan.			9

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 10: The Trust is unable to meet the required national urgent and emergency standards.			**Chief Operating Officer**	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is CAUTIOUS and prefers not to take risks to the achievement of internal and external performance standards where there is likely to be adverse consequences.**			**FPAC (financial impacts) and QSAC (patient/ quality/ safety related)**						
Risk opened: risk within 2021/22			Sara Biffen											

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	Upper tolerance level
Cause: • lack of acute bed capacity and workforce. • Increase in complexity of demand and length of stay • Staff becoming progressively more tired due to ongoing pressures. • Community capacity for pathway 3 insufficient to meet current needs for timely discharge • Primary and community health and care capacity not meeting pre-hospital demand • Continuing industrial action **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Urgent work impacting on elective capacity • Leads 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 • Delays to improvement work due to industrial action planning and workforce cover	4	5	20	• Getting To Good (G2G) Urgent & Emergency Care (UEC)programme. • Work on System, Urgent and Emergency Care Plan • ICS UEC Committee • 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. • Multi-disciplinary check chase challenge put in place for discharges. • Taking forward the recommendations following the GIRFT visit in January 2024. • Weekly Metrics meeting with system partners chaired by the Chief Operating Officer • UEC project initiation document in place including implementation plan and Gaant chart.	**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) • Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) • ICS UEC Committee - monthly (2nd) • Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) • Monthly reporting to the CQC (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) • Internal Tier 1 meeting - weekly (2nd) • Tier 1 monthly meeting with national director of UEC (2nd)	4	5	20	**Gaps in control:** 1. Workforce challenges, including consultants, nurses, HCA's and middle grade doctors. 2. Inpatient bed capacity is not expected to meet demand. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Ongoing recruitment 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, throughout 2024-25. Executive lead: Chief Operating Officer and Director of People & OD. 2. Improve/reduce length of stay for urgent and emergency pathways, in line with national standards; Executive Lead: Chief Operating Officer: 2a. Reduce number of people in our hospitals who are over 14 and 21 days by March 2025. 2b. Improve the utilisation of virtual ward step down beds by March 2025, by incorporating it into the effective board round. 2c. Reconfigure services on the PRH site to right size the acute medical bed base by end June 2024. 2d. Create frailty assessment units on both sites by end June 2024. 2e. Reduce length of stay for no criteria to reside patients to three days by March 2025.	1. Recruitment ongoing and in progress. Work continues to recruit to national difficult to recruit positions within the medical workforce. 2. Work ongoing to achieve the timescales identified in the implementation plan for this overall action.			9

Reference and risk title			Lead Executive	Link to strategic themes	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 Hospitals Transformation Programme (HTP)**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**Recognising the current position with the Trust's estate, SaTH is OPEN to transforming its buildings/infrastructure to support better outcomes and experience for our patients and public. We will consider benefits and solutions which meet organisational requirements and ensure a safe environment.**			**HTP Assurance 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	Upper tolerance level
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, in line with local care transformation programme. **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	• Hospitals Transformation Programme (HTP) - the Trust has now received national approval of its full business case for the programme. This will release the capital investment required for local services and the implementation of a new model of health care in the county, including construction, can now begin. • System, Urgent and Emergency Care (UEC) Plan was produced for 2023/24 - led by ICS UEC Board supported by UEC Operational Group. This remains in place. • Now that the FBC has been approved, work will begin in earnest to build detailed clinical pathways that support safe transfer and transformation of services from the current operating model to the new model of care. Priority is being afforded to urgent and emergency care pathways and work with ICS/UEC partners has begun. In parallel to the service transformation work being done in preparedness for the completion of the HTP build, clinical teams are reviewing options for accelerating any pathways that can be expedited prior to HTP 'go live' e.g. (1) elective surgical hub at PRH (opened 10 June 2024); (2) critical care model; (3) support to the ICS local care programme for community based pathways. • 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 - public/private) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (monthly) (2nd) • HTP Assurance Committee (monthly) (2nd) • HTP Programme Board (monthly), including system partners and ICS members (2nd) • UEC plan to ICS UEC Board - monthly (2nd) • Independent Reconfiguration Panel produced/published a report that made 13 recommendations in relation to HTP which agreed with the HTP delivery mechanism to deliver outcomes for the population of Shropshire, Telford & Wrekin - December 2024 (3rd)	4	3	12	**Gaps in control:** 1. Elective surgery hub (first scheme) short form business case submitted to NHSI in June 2022 **Gaps in assurance:** 2. Personnel (HTP and Divisional), demand and capacity, dependency on system-wide programmes and governance to be expanded as part of full business case stage.	**Actions aligned to gaps:** 1. Implementation of the elective surgery hub build. Executive lead: Chief Operating Officer. By end of 2023/24. 2. 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, throughout the HTP Programme. (The Director of Finance is also a core member of the HTP Programme Board.) Executive lead: Director of HTP.	1. 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 has been underway at PRH site and opened on 10 June 2024, as per schedule. **Action closed Q1.** 2. 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 (and the ICB local care transformation programme lead attends HTP Programme Board). Q4: A gateway 3 review of the full business case governance processes has been completed, with the delivery of confidence assessment showing as 'Green'. Action ongoing.			12

Reference and risk title			Lead Executive	Link to strategic themes	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 and Director of Strategy & Partnerships**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is keen/EAGER to form collaborations and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve. Guiding principles or rules will be in place that welcome considered risk taking in organisational actions and the pursuit of, for example, partnership and collaborative working priorities.**			**Quality & Safety Assurance Committee**					
Risk opened: 1 April 2022			Sara Biffen and 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	Upper tolerance level
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 long-term condition management, e.g. diabetes **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 • 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 • System Quality Risk Register reported to ICS Quality and Performance Committee.	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 and delays within urgent and emergency care caused by lack of flow. 4. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. **Gaps in assurance:** 5. Robust population health data intelligence.	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Local Care Programme (LCP) - ongoing. Lead Executive: Chief Operating Officer and Medical Director 2. *Not a SaTH action to lead* 3. See actions within BAF risk 10. 4. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement. 5. *Not a SaTH action to lead*	1. Revised approach to LCP tabled at ICB meeting at end of November 2023. The continued importance of the interdependency between Hospital Transformation Programme (HTP) and the LCP was reinforced by the report from the Independent Reconfiguration Panel which reported in December 2023 to the Secretary of State. Attendance at the LCP meetings remains under review. 2. SaTH taking part in this work with all partners. Clinical pathways to be reviewed and agreed. 4. SaTH taking part in this work with all partners. Clinical pathways to be reviewed and agreed. 5. Established system health population health management group in place at ICS level which is supported by a system business intelligence leads group - SaTH is represented on both groups.			16

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 13: The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance			**Director of Governance**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH has a MINIMAL appetite to compromise legal and regulatory standards. We are only prepared to accept the possibility of very limited deviation from compliance during exceptional circumstances.**			**Audit & Risk Assurance Committee**					
Risk opened: 1 April 2023			Anna Milanec										

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	Upper tolerance level
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 • 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, with ongoing review • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and refreshed 2023 • Managing Conflicts of Interest Policy updated during 2023 • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests published on the Trust's website • Terms of reference refreshed for all assurance committees of the Board during 2023/24 • Review of effectiveness of FPAC and QSAC committees June/July 2023 • Committee effectiveness session held with Board in January 2023 • Scolding Review action plan • DSPT action plan in place and cyber security exercises planned at local and ICS level • Fit & Proper Person Policy updated following publication of new national framework • Fit & Proper reporting status established within the Electronic Staff Record (ESR)	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit Committee and Board during December 2023 (2nd) • BAF considered quarterly at Board and its committees (2nd) • Managing Conflicts of Interest Policy approved at Audit Committee and Board during 2023 (2nd) • Refreshed terms of reference considered at all Board committees during 2023/24 (2nd) • 2023/24 Annual Report to Board in June 2023 and due to be published on Trust's website (2nd) • Auditor's Annual Report 22/23 published on Trust's website, with 23/24 report due (3rd) • Annual General Meeting held in public (face to face) - 30 August 2023 • Head of Internal Audit Opinion April 2024 providing Substantial Assurance that there is a good system of internal control (3rd) • Data Security and Protection Toolkit 2023 submitted (June 2023) with 'approaching standards' outcome • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% by March 31st 2024 (2nd), with subsequent associated Counter Fraud Authority Standard achievement confirmed by internal audit (3rd).	4	3	12	**Gaps in control:** 1. Trust Policy Framework. 2. Timely review of internal audit recommendations. 3. Outstanding subject accesss requests (SAR's), and subsequent complaints. **Gaps in assurance:** 4. Data Security & Protection Toolkit assurance. 5. BAF not aligned with the Trust's strategic 'themes'.	**Actions aligned to gaps:** 1. Introduce refreshed Policy for Policies and Policy Approval Group in Q2 24/25. Lead Executive: Director of Governance. 2. Lead executives to review and action in a timely manner all internal audit recommendations. Lead Executives: All 3a. Fully staff the department, and train - by Q1. Lead Executive: Director of Governance. 3b. Senior manager put in place to support training and establishment of new processes within legal department. c. Procure a company to scan the medical records (by Q1) for SAR's to assist with backlog. Clear the backlog by Q3. d. Director of Governance to continue to liaise with the ICO - ongoing. 4.Deliver DSPT action plan by end of March 2025. Lead Executive: Director of Governance. 5. Add strategic themes to BAF in Q1. Lead Executive: Director of Governance.	1. Phase one was completed in 23/24 regarding scoping of current processes, with policy framework review completed, including delegations of authority. Options proposed and agreed in December 2023 with Executives. Work to update and agree Policy for Policies remains ongoing and to be considered by new Policy Approval Group. Policy Approval Group meeting dates now established and commencing in Q2, 24/25. 2. Director of Governance now has access to the system where audit recommendations are held. To be raised at executives meetings monthly. 3a. **Action complete and closed Q1.** b. Senior manager is in place. Work remains ongoing. c. Company has been procured and scanning has begun. d. Ongoing. 4. The Trust's current DSPT standards status at 30 June 2024 is 'approaching standards'. -Work is ongoing to complete the annual DSPT assessment by 31 December 2024. 5. Completed Q1. **Action complete and closed Q1.**			6