Ref	Risk Description	Current Context	Risk Owner	Initial Risk (Ixc)	Current Risk (Ixc)	Provisional Target Risk* (Ixc)	Existing Controls	Assurance	Action Required (with timescale to complete)
	What might happen if the risk materialises.	*What is the cause of the risk*		*Without Controls*	*With Controls*		*What is currently in place to mitigate the risk*	*Evidence that the controls are effectively implemented*	*Gaps in controls or assurance*
SR1/18	**Financial deficit in excess of planned levels** Any material financial deterioration against the Trust's financial plan may result in: * Reduced 'Use of Resources' score which forms part of the NHS regulators measurement of providers * Decrease in central sustainability funding thus reducing Trust cash balances * Requirement for additional financing (working capital loans) which in turn leads to increased interest costs. * Regulatory intervention leading to constraints in decision making by Board * Adverse media coverage leading to reputational damage	The year on year impact of national tariff efficiency requirements, combined with changes to contract rules (marginal rates, fines, penalties) has increased the financial pressure on all NHS providers. This risk may occur as a result of: * Higher than planned expenditure due to factors such as; failure to meet CIP targets, cost pressures for winter and emergency activity, increased procurement costs as a result of BREXIT, or continued high use of agency staff. * Lower than planned income due to operational pressures, cancellations or data quality issues. For 2020/21 as a result of the COVID-19 pandemic, an emergency financial regime has been introduced for the first 4 months of the financial year which guarantees the Trust will deliver a breakeven position. Efficiencies / CIPs at this point have been suspended. The regime following this period is less clear but it is expected to re-introduce incentives to reduce and control expenditure within a fixed envelope. The fixed envelope and incentives may be based loosely on national tariffs.	CFO	20 (5x4)	6 (2x3)	6 (2x3)	Trust Interim Plan. Monthly reporting to NHS Improvement and Board including expenditure and income Internal policies and procedures SFIs / Standing Orders Scheme of Delegation Trust financial system (SAGE and ORACLE) reflects the approved SFIs and Scheme of Delegation Key senior appointments made to finance team	Trust Interim Financial Plan approved by Board in April 2020 Internal: Monthly financial reports to BoD, CEAG, CCQ meetings Monthly financial meetings with operational divisions Bi-monthly exec performance reviews Head of Internal Audit opinion and external audit/going concern assessment External: External Audit reviews and Counter Fraud Service Assessment External assessment of effectiveness of Counter Fraud Service assessed as adequate The Trust reported it delivered the financial plan for 2019/20.	Support Internal Auditors with on-going scrutiny and assurance - **On-going** Medical efficiency programme (focus on locums & job planning) - **On-going** Roll out of a range of other initiatives to identify further efficiency opportunities - **On-going** At the point that guidance is issued for August, gain an understanding of the impact to the Trust and plan/budget accordingly - **On-going**
SR2/18	**Cash flow affects day to day operations of Trust** If the Trust cannot maintain a sufficient cash balance this may result in: * Delayed payment of staff salaries resulting in increased staff turnover and decrease in morale * Requirement to source additional funding which may lead to increased costs and regulatory pressure * Delayed payment of invoices to suppliers may stress the supply chain and affect our ability to procure goods and services * Adverse media coverage may lead to reputational damage	This risk may occur as a result of: * Like most providers of acute hospital care, the Trust delivered an underlying deficit in 2019/20 relying on central funding of £36.2m which was largely dependant on the Trust delivering its plan. Trust cash balances were maintained throughout 2019/20 with a year end cash balance of £61.0m, £6.9m favourable to the planned levels. Emergency financial regime at the start of 2020/21 has ensured the Trust cash balances are adequate to ensure all additional costs can be absorbed and timeliness of supplier payments. * Issues that may be encountered post month 4 are: - Lower than planned income due to factors such as the ability to meet operational and activity targets, - late payment of invoices by 3rd party and other NHS providers, - data quality issues and - ability to take advantage of innovation opportunities.	CFO	15 (5x3)	6 (2x3)	6 (2x3)	Trust Interim Financial Plan. Weekly cash meetings to manage cash flow and discuss cash management measures Working capital loan agreed in principal as part of the merger discussions Sales ledger and treasury management team are aligned and working to consistent processes Good relationships with key commissioners who are responsible for the majority of Trust income.	**Internal:** Approved (April 2020) Trust interim financial plan for months 1-4, 2020/21 at a level consistent with national assumptions Cash positions reported to Board each month SFIs/Standing Orders Scheme of Delegation Monthly financial return for cash balance and cash forecasts reported to Board **External:** Monthly financial return for cash balance and cash forecasts reported to NHSI. Block contract values for months 1-4 agreed with commissioners thus securing consistent monthly cash payments Received all of 2019/20 central funding.	
SR3/18	**Prolonged and/or substantial failure to meet operational performance targets** Failure to achieve operational performance targets for: * 4 hour ED target * Cancer 62 day * RTT * Diagnostics may impact on the following: * Financial delivery of CIP and use of resources, productivity and efficiency * Potential for unintended harm to patients due to longer waiting times which may result in increasing number and severity of incidents and claims * Patient experience may fall below the required standards which may lead to an increasing number of complaints * Reputational damage may arise as a result of adverse media coverage * Regulatory action may lead to loss of licence or service and constraints in Board decision making * Financial penalties and loss of income which may lead to unfunded expenditure for some indicators * Ability to deliver the Trust's Annual Plan	The main factors that effect the ability of the Trust to deliver operational performance targets are: * Period of severely reduced activity due to Covid19 * On-going reduction in elective throughput due to Covid19 recovery phase e.g. social distancing, IPC precautions, staff shielding * Demand for acute, specialist and tertiary services exceeds the Trust's capacity. * Out of area referrals *High demand in ED * Other Tertiary growth * Timeliness of tertiary referrals (referrals received after breach) * Flexibility of staffing levels to meet increasing demand * Clinical equipment and Estate * Delayed transfers/ partner agencies	COO	25 (5x5)	20 (5x4)	9 (3x3)	Divisional Performance Management Framework which includes quarterly performance reviews. Chief Operating Officer's group (COOG) and sub groups to track, monitor and improve performance across the Trust as follows: - Scheduled Care - Cancer - Urgent Care - Financial improvement groups Controlled documents addressing: *ED Standards/Bed Capacity *Cancer Tracking *RTT Management inc diagnostics	**Internal:** Performance against national targets and waiting list size - performance reports to COOG, CEAG and BoD. Comprehensive restoration and recovery plans have been enacted as part of the Trust's 'Phase 2' operational response to the COVID-19 pandemic. These include the continuation of a senior clinician leadership model to support effective urgent care delivery, maintain flow and avoid congestion in ED. Elective recovery plans have focused on a model of clinical prioritisation and stratification in line with NHSE/I requirements and regional guidance. This has involved the repurposing of Solihull hospital and a designated area within QEH as COVID-19-secure elective facilities in order to enable the recommencement of urgent elective surgery and diagnostics. Phase 2 project groups include cold site elective working, outpatients, diagnostics, medical day cases, T&O, Thoracics, Gynaecology and Paediatrics, use of Independent Sector capacity, ED front door models, maximising use of Solihull site. Collaborative demand and capacity modelling undertaken jointly with CCG. Implementation and adherence to national and regional guidance in relation to clinical prioritisation, IPC measures, safety netting and monitoring of waiting lists. Extensive clinically-led validation of outpatient and inpatient waiting lists by operational Divisions. Categorisation of elective patients against national criteria in order to ensure that existing capacity is used for the most urgent patients. Specialty specific action plans developed for high priority/risk services. Escalation processes run in parallel to Divisional/specialty waiting list meetings to ensure long waits are addressed. Tumour specific Cancer Patient Tracking Meetings (PTLs) meet weekly for all major tumour types to assess capacity, identify delay issues and themes and forecast current and future performance and risks. Delays and required actions are escalated twice weekly to operational teams and feed into divisional assurance meetings. Divisional internal assurance meetings take place 1-2 times per month and are supported by Cancer Services both through the provision of performance information and by reinforcing the confirm and challenge arrangements around specialty-level recovery plans. CCQ papers and minutes Monitoring figures for ED performance and capacity via bed meetings and dashboards. Short, medium and long term plans. Regular, clinically-led UHB elective prioritisation meeting to ensure best use of available theatre lists (both internal and in Independent Sector). **External:** NHSI/CCG/ and UHB assurance meetings	Continue to actively monitor the delivery of recovery action plans - **On-going** Specific specialties subject to targeted support in further developing and delivering improvement action plans - **On-going** Review of Access Policy to support Phase 2 recovery. - **On-going** Informatics and IT support to align and amend reporting arrangements from the multiple systems - **On-going** Review of existing operational performance monitoring and reporting arrangements to ensure fit for purpose in context of Phase 2 recovery and restoration. - **September 2020** Implementation of 'Phase 2' elective recovery plans to restart elective surgery and diagnostics, based on a model of clinical prioritisation. - **June 2020** Consolidation of the 'Senior Responsible Clinician' model of leadership and associated cross-Divisional plans to maintain improvements to urgent care delivery and flow. - **June 2020**

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SR4/18	**Increasing delays in transfer of care from UHB sites in excess of agreed targets** Delays in the transfer of care for patients may result in the following impact and consequence: * Pressure on patient flow which impacts on quality of care and patient experience. * Requirement to increase capacity on an ad hoc basis may lead to increased cost * Adverse media coverage may lead to reputational damage * Longer waiting times may lead to missed operational targets * Capacity to admit new patients may lead to patient safety issues * Missed operational targets may lead to loss of income and financial penalties	Delayed transfer of care may be caused by: * Patient and relative choice * Capacity in nursing and residential accommodation * Delays in availability of care packages *Awaiting completion of internal and external assessments * Awaiting the provision of care by other NHS providers * Awaiting Mental Health on-going care.	COOOHS	25 (5x5)	12 (3x4)	9 (3x3)	* Internal Monitoring and Management of patients referred for social care intervention and CHC nursing assessments via hospital discharge hubs overseen by senior managers from the council and Trust including daily board rounds. * Provision of the step down capacity through Supported Integrated Discharge (SID), Recovery at Home (R@H) and from Homewood ward at Good Hope Hospital from Dec 18. * EICT home based health and social care community team rolled out across Birmingham. *Regular meetings with senior managers from South Staffordshire and Solihull focusing on DTOC action plans and performance. * Weekly system meeting established focusing on CHC performance chaired by UHB management representative. * BHH, GHH, & SHH operational representatives are members of Solihull Together work programme with SMBC and BSOL CCG on system working to reduce DTOC. * Weekly escalation meetings in place with Chief Officer Out of Hospital Services and the Chief Legal Officer to try to resolve complex cases with long length of stay, examples include patients without recourse to public funds. * DTOC performance on BSOL A&E Delivery Board agenda which is chaired by the UHB Chief Executive. *Chief Executive Officer corresponds frequently with NHSE/NHSI/CQC. * Conference calls with partners escalating delays and quality concerns for resolution by partners. * As part of the BSOL STP work the Early Intervention workstream has commenced the system transformation work for older people.	**Internal:** * QE electronic tracking system with daily board round records for each patient and agreed actions. * Daily board round evidence from BHH, GHH and SHH sites. * Weekly DTOC reports for all sites. * Daily Medically for Discharge reports for each site including intermediate care beds managed by Birmingham Community NHS Foundation Trust (BCHC) * Minutes from weekly System Discharges and Care Homes meeting chaired by the BCHC CEO. * Board performance papers and minutes * BSOL Early Intervention Steering Group minutes. The workstream comprises all system partners, is chaired by the UHB Chief Officer of Out of Hospital Services and reports into the BSOL STP Ageing Well and Later Life portfolio * Birmingham Older Peoples Project Board minutes * Feedback from Executive meetings with Government leads to establish influence over policy and strategy **External:** * BSOL A&E Delivery Board papers and minutes. * BSOL Birmingham Ageing Well & Later life Board papers and minutes. * Newton system diagnostic analysis and findings November 2017. * STP Board papers and minutes February 2018. * Solihull Together minutes	The system response to COVID-19 focusing on keeping DTOCs at this level or below during Phase 2 to optimise acute and community bed capacity to support restoration of services - **On-going**
SR5/18	**Unable to recruit, manage and retain adequate staffing to meet needs of patients** If the Trust cannot recruit, control and retain adequate staffing then this may lead to: * Impact on quality and patient experience which may lead to formal complaints and CQC intervention * Unintended harm to patients which may result in increasing number and severity of incidents and claims * Inability to meet financial targets which may lead to unfunded expenditure * Adverse media coverage and reputational damage * Adverse effect on staff morale leading to increase in absence and retention difficulties *Spending above planned levels that may lead to pressure on control total * Ability to meet legislative requirements relating to staffing may lead to financial penalties	Inability to meet the Trust's staffing model may be caused by: * Ability to recruit sufficient numbers and skill mix of staff. This is made worse by national shortages, the effect of BREXIT uncertainty on EU staff and adverse media coverage which may make the Trust seem a less attractive employer * Compliance with policy and procedures that enforce standards of employment and required ways of working * Retention of staff who are in post	CWIO	20 (5x4)	16 (4x4)	12 (3x4)	*Recruitment plans for clinical professions. *Workforce policies and procedures *Retention Strategy *Leadership and management education programme established for middle and senior managers *Mentorship and Coaching freely available through leadership portal on the website. *Top Leaders programme available through NHS Academy with sponsorship for additional bespoke programmes identified. *Daily and weekly review of staffing levels and skill mix *Use of bank and agency with robust monitoring system and Exec sign off *Health and Well Being Initiative *Agenda for Change 3 year pay deal (18/19 onwards) *Harmonisation of bank rates *Enhanced use of social media for recruitment *International Fellows Programme *Cross-site working harmonisation	The Trust wide Workforce Group meets bi-monthly to receive reports from steering groups representing all professions. TWG then provide updates to Trust Board and CEAG The Medical Workforce Group chaired by CWIO, receives assurance from professional groups relating to medical staffing An Annual Workforce report is submitted to Trust Board that details performance and updates on HR management The Trust's Retention Group, chaired by Director of Nursing, reviews and develops plans to retain staff The annual NHS Staff survey, and the Staff Friends and Family survey, provide a valuable feedback loop to the Trust to inform local improvements in staff experience and well-being Training records allow for monitoring of training status of staff Internal Audit Tier 2 Visa Report (May 2019) reported to Audit Committee. The report provides significant assurance with minor improvements opportunities 2019/20 Workforce planning return submitted to NHSI/HEE	Continue support of Nursing Associates Programme - **On-going** On-going communications regarding the recruitment and retention package including the Agenda for Change pay deal enhancements – Pay progression changes to be implemented **Q1 2021/22** Decision and potential commission of new recruitment management system - **On-going** STP Workforce Planners Group to develop STP wide dashboard on progress towards Annual Plan - **On-going**
SR6/18	**Material breach of clinical and other legal standards leading to regulatory action** Where a regulator takes action against the Trust this may lead to any of the following: * Licence conditions which introduce constraints in decision making by Board * Financial penalties incurred may lead to unfunded expenditure. * Adverse media coverage may lead to reputational damage. * Mandatory improvements may lead to unfunded expenditure.	Regulatory action may take place following a failure to adhere to statutory and regulatory requirements, national guidelines and audits and (inter-)national standards and accreditations (e.g. CQC, clinical audits, MHRA, HSE, UKAS, etc.) and threat to UHB sustainability and licence conditions.	CLO	16 (4x4)	8 (2x4)	4 (1x4)	Governance Declaration - The Board of Directors receives a draft annual report outlining the Trust's proposed annual governance declaration in March every year. This declaration is then signed off in the following May and submitted to NHS Improvement to ensure the Trust maintains compliance with its obligations. Strategy & Performance Team Performance Monitoring Arrangements The Clinical Compliance Framework has been implemented within specialties as a way to provide assurance that areas are meeting the CQC's Key Lines of Enquiry (KLOE's). This includes specialty self-assessment. Controlled documents and processes in place to: * Manage national and local audits to ensure evidence shows compliance with that process. * Manage incidents and identify trends. * Manage new and existing NICE guidance to ensure there is evidence to show compliance and where we are not able to adhere to the guidance e.g. we do not provide the service, the Medical Director's approval has been obtained. * Manage NCEPOD studies and identify actions, in conjunction with the clinical teams in response to the outcome of the relevant study. * Manage oversight of any external visits * Manage the QSIS specialised services peer review programme The Corporate Compliance Framework's purpose is to assure that required actions are being carried out by those who have that responsibility, and to alert/escalate appropriately when they are not. The Corporate Compliance Framework allows the Trust to understand its Corporate Compliance position regarding legislation and regulatory requirements. It will also include actions from regulatory inspections. Annual health and safety inspections at local level Data Security and Protection Toolkit (previously known as the Information Governance Toolkit) Unannounced Board of Directors visits are arranged on a monthly basis and are led by either the Executive Medical Director or the Executive Chief Nurse. Lead and monitoring groups set up for each of the CQC 'Must Do' Actions overseen by the Director of Corporate Affairs.	**Internal:** Board Meeting Minutes Annual Governance Declaration Good Governance Institute Report **Internal:** Quarterly Board Meeting Minutes Quarterly Divisional Performance meetings Contract review meetings Internal Audit **Internal:** Presentation at BOD seminar in May 2016 Quarterly compliance reports to BoD and Audit Committee CQC external report published 13th February 2019 DCA Group minutes Compliance Framework reports to DCQG meetings every quarter **Internal:** Quarterly compliance reports to BoD DCA Governance Group minutes National Audit presentation to CQMG Clinical Quality Monitoring Group (CQMG) Divisional Management Teams Health and Safety Executive Committee minutes HSE investigation outcome into the Trust's management of Occupational Dermatitis Information Governance Group minutes Policy Review Group minutes DCQG quarterly compliance reports **External:** QSIS self-declaration Internal Audit report of Health & Safety Procedures within Estates **Internal:** Exception reports for non-compliant actions reported to Director of Corporate Affairs' Governance Group Progress on completion of actions reported in quarterly Compliance report Leads submit progress reports on actions and provide evidence on compliance with each action. Progress against actions reviewed regularly in conjunction with CQC relationship managers.	Implement actions from Improvement Plan for Data Security and Protection Toolkit - **Q2 20/21** Implement actions from CQC review - **On-going** Review of Statutory Compliance - **Q2 20/21** Implement improvement plan relating to Radiotherapy services and provide assurance to CQC - **Q2 20/21**

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SR7/18	**Failure of IT systems to support clinical services and business functions** If the Trust's IT systems do not support the Trust adequately then this may lead to: * Service disruption which impacts on safety, quality and patient experience. * Adverse media coverage and reputational damage. * Adverse effect on staff morale leading to increase in absence and retention difficulties. * Loss of personal data that may lead to regulator intervention and fines * Decrease in data quality which may impact on income or ability to meet reporting requirements and may increase pressure on clinical staff	Issues that may have an impact on the ability of IT systems to support the Trust include: * Appropriate skills and number of IT staff * Cyber security attacks * Quality of IT infrastructure * Failure of 3rd party providers * Malicious intent/staff actions	MD	25 (5x5)	16 (4x4)	4 (2x2)	Full Business continuity plans Emergency Preparedness Policy and Procedure Service management processes in place Security standards and policies implemented Regular data backups and checks that the back-ups have integrity ISO 9001/ISO 27001 certified Recovery Plans/Contingency Plans for critical systems Workforce Plan Quality Management System Telephone system replacement solution Data Centre which is fit for purpose and has sufficient capacity A Health Informatics/Business Intelligence function is established	Reports from table top exercises. Documented and approved service management processes Architectural reviews of all system and infrastructure designs to ensure they meet compliance with industry standards. ISO 9001/ISO 27001 last LRQA Audit was 13th April 2018 - certificate maintained Bi-monthly updates to IG Group Validation of table top exercises by an external auditor. ISO 9000 (BHH, GHH and SHH sites) Monthly updates to Digital Healthcare Group Change Advisory Group (weekly) Escalation of any unscheduled downtime to the Executive led RCA Forum during weekly RCA meetings to review Priority 1 RCAs ISAG (monthly) Cyber reports to Audit Committee (quarterly) Monthly updates to Emergency Planning Group (for BCP)	On-going review of workforce requirements and plans to inform QMS Manual (ISO9001:2015 7.2) - On-going Review of processes and rolling modernisation of technical security control - On-going Consolidation of policies and procedures - Q2 20/21 Install EPR at Heartlands, Good Hope and Solihull sites - Sept 20 Network, wireless and telephone capital milestones work programme continues and is on plan - March 21 Delivery of Informatics implementation plan for ISO9001 - On-going Development of systems to support new model of care delivery - On-going Review and improvement of change controls procedure for local and third party systems - Q2 20/21
SR8/18	**Adverse impact of BREXIT on Trust's innovation agenda** If the Trust is unable to maintain progress then this may cause: * Increase in procurement costs leading to unfunded expenditure * Limited access to European research networks * Inconsistent supply of products leading to adverse impact on quality of service * Delays in new products being developed and coming to market * Access to markets for new and current products * Ability to attract appropriate research staff *Migration system inhibit the free movement of scientists, researchers and scientific technicians * UK trials are no longer able to recruit European patients which would lessen the benefits for patients	The main cause of this risk is the uncertainty related to the future of funding and innovation frameworks as a result of BREXIT.	CIO	16 (4x4)	12 (4x3)	8 (4x2)	Membership of overseas research networks Exploration of non-EU trials work Strategic alliance through Birmingham Health Partners (BHP)who continue to lobby regarding Brexit uncertainty Working with Pharma companies to provide a premium service Tier 2 visa regime for doctors, nursing and high-tech staff MDTEC ventilator assessments fast track approval of technical products	UHB Chair and CEO are members of the BHP Board and meet quarterly BHP Executive Board meet bi-monthly BHP Research updates to UHB Board 6 monthly Strategic Research Executive Group update the Board Memorandum of Understanding with the Association of British Pharmaceutical Industries Annual Research Governance paper to Audit Committee	Monitoring of current landscape and developments - On-going Lobbying of decision makers through Birmingham Health Partners - On-going Lobbying through the Association of UK University Hospitals, and attendance at their Briefing Sessions - On-going Develop close working links with the Association of British Healthcare Industries (ABHI) - On-going
SR12/18	**Unable to maintain and improve quality and quantity of physical environment to support the required level of service** The current estate for the Trust may not be able to provide sufficient quality and capacity to support the services required, this could lead to: * Service disruption which impacts on quality and patient experience * Longer waiting times and missed operational targets * Adverse media coverage and reputational damage * Adverse effect on staff morale leading to increase in absence and retention difficulties * Opportunities to improve service and business not fully realised leading to increased cost and loss of income	The estate requires continual maintenance to meet the current service requirements and improvement to meet future need and realise opportunities. This may be difficult to achieve because of: * The poor quality of the current estate in some areas of the Trust * Ability to meet requirements of maintenance program * Funding for new capital projects * Alignment of Estates strategy to meet future requirements.	CTO	25 (5x5)	16 (4x4)	9 (3x3)	Proactive risk management system to continuously measure and monitor risk and prioritise investment and allocation of resource Comprehensive Planned Preventative Maintenance Programme that ensures the Estate, Plant, Infrastructure and Equipment is safe, compliant and utilised to its maximum capacity and full lifecycle Reactive Maintenance SLA to ensure the Estates, Plant, Infrastructure & Equipment are returned to use in a timely manner Priority risk based annual Capital Bids to improve the Estate and upgrade Plant, Infrastructure Equipment etc. Scheduled Divisional reporting and monitoring Estates operational strategy and workforce model Customer satisfaction survey Site based specialist teams responsible for fire safety, asbestos management, medical gases and other regulated activity. Governance structure and processes established to monitor passive fire protection (PFP) plans at QEHB. Implementation is led by the Technical and Operational Group	PFP Steering Group develop and monitor plans to be implemented by Technical and Operational Group. Estates Department Performance & Assurance Framework Monthly Directorate Statutory Compliance Group Assurance Meeting Monthly Chief Transformation Officers Group to scrutinise operational activity in Estates and provide assurance to Executive Capital Planning Group conduct scrutiny and overview of the Trust's planned maintenance to ensure that priorities are identified Chief Operating Officers Group Internal Audit Programmes External Accreditation to ISO9001 & ISO14001 standards (BHH,GHH and SHH sites) Six Facet Property Condition Survey (BHH, GHH and SHH sites) ACAD Steering Group monitoring project and provides assurance to Board	Determine which clinical services are to be provided from which site to balance use of the existing Estate - On-going Estate Strategy for all Trust sites to be approved -On-going Implementation of Estates workforce review recommendations - Q2 20/21 Realignment of significant investment in Estate (ACAD) development to meet Clinical Needs and proposed development - 2022 Site plans and subsequent Six Facet Property Condition Survey for Heritage Site - Q3 20/21 Evaluation of technical recommendations to inform plans for remedial works and PFP improvements - On-going West Midlands Fire Service will undertake an audit of preventative fire arrangements at QEHB. Q2 20/21
SR13/18	**Failure to realise opportunities and benefits of merger** If the Trust does not realise the benefits of the merger that took place in April 2018 this may lead to: * Service disruption and inefficiencies which impact on safety, quality and patient experience * Adverse effect on staff morale leading to increase in absence and retention difficulties * Increasing costs and unplanned spending * Adverse media coverage and reputational damage.	Issues that may have an impact on the Trust's ability to realise the benefits from merger include: * Lack of clinical engagement * Cultural differences * Communication around the integration process * Failure to learn lessons from previous integration *Completion of successful integration	CWIO	20 (5x4)	12 (3x4)	8 (2x4)	Strategic Operations Steering Group (SOSG) Technical Integration Group (TIG) Agreed integration plans and schedule Agreed integration process Senior leads identified for more complex integration areas	Monitored through SOSG meeting SOSG reports to BoD	No further actions - risk to be accepted with approval of Board of Directors
SR1/19	**Prolonged and/or substantial failure to deliver standards of nursing care** As a result of inconsistencies in care relating to: -Safeguarding Patients -Falls Prevention and Management -Infection Prevention and Control -Tissue Viability -Nutrition and Hydration -Patient Experience -End of Life Care -Vulnerable Patients there may be a prolonged or substantial failure to achieve care standards that could result in: * Harm to patients * An increasing level of remedial treatment and care * Increased length of stay * Additional complications that may delay transfer of care * In severe or on-going cases a regulator may intervene which may lead to constraints in decision making by Board * Adverse media coverage may lead to reputational damage.	Standards of nursing care are specified in Board agreed frameworks that dictate the required levels of intervention and practice to deliver the best possible outcomes for patients. The Trust may not meet these standards due to: -Clarity of standards and frameworks especially where practice may be different across sites -Incomplete training and competencies -Inconsistencies in governance arrangements -Inability to recruit and retain the right numbers and skill mix of nursing staff -Individual substandard practice of registered health professionals	CN	20 (5x4)	12 (3x4)	6 (2x3)	Internal policies and procedures detail the required standards and practice for nursing care in each specialist area Specialist Corporate Nursing Teams that support on-going monitoring, scrutiny and improvement of standards of care Corporate Induction and on-going mandatory training for all staff outlines required standards of practice and care Ward level quality dashboards that provide real time data in relation to standards of care Nursing metrics that routinely monitor standards of care Reporting and Management of Incidents via Datix provides a route for all staff to raise concerns and report issues.	Care Quality Group, chaired by the Chief Nurse, receives monthly assurance reports from steering groups responsible for the following areas: -Safeguarding Patients -Falls Prevention and Management -Infection Prevention and Control -Tissue Viability -Nutrition and Hydration -Patient Experience -End of Life Care -Vulnerable Patients The specialist steering groups monitor compliance and performance with standards, ensure issues/incidents are recognised, acted upon, reported and lessons are learnt and shared. Chief Nurse Workforce Group reports to Trust's Strategic Workforce Group regarding workforce plans and progress Nursing Incident Quality Assurance and Management Group (NIQAM) review all incidents that may result in severe (reportable) harm, quality assuring investigation reports, identifying and sharing lessons, escalation if required, ensuring the contractual requirements in relation to reports to the Commissioners are met.	Launch new NG Tube standards and Procedure - Q2 20/21 Develop and Implement process to provide assurance that staff completing insertion, management and position checking of NG tubes are competent/credentialed. - Q1 20/21 Develop PICS documentation for insertion, placement checking and care of NG tubes - Q2 20/21 Review and update Nutrition and Hydration Management Strategy - Q2 20/21 Revised SOP for the Assessment of 16-18 yr olds to be implemented – Q2 20/21 Implement changes to named Doctor for Child Protection in community – Q2 20/21 Review all audit information in relation to safeguarding assessments/ safeguarding referral activity to offer assurance in relation to compliance with safeguarding procedures - Q2 20/21 Implement revised MCA/DOLS standards - Q2 20/21 Develop on-line training in relation to MCA/ DOLs that is linked as a requirement for all relevant clinical staff - Q2 20/21 Review and update of Falls Reduction Strategy - Q2 20/21 Review and improvement of falls data collection systems to provide more robust assurance - Q1 20/21 Align frameworks for Tissue Viability prevention and management - Q1 20/21 Develop new training and competency assessments for all staff in relation to Tissue Viability prevention and management - Q2 20/21 Develop and approve a policy with procedures in relation to the care requirements / needs of vulnerable patient group to improve identification, escalation, communication, care and documentation - Q2 20/21

Appendix A Board Assurance Framework - Quarter 1 2020/21			* Target scores are for consideration and approval by Board of Directors						
Ref	Risk Description *What might happen if the risk materialises.*	Current Context *What is the cause of the risk*	Risk Owner	Initial Risk (Ixc) *Without Controls*	Current Risk (Ixc) *With Controls*	Provisional Target Risk* (Ixc)	Existing Controls *What is currently in place to mitigate the risk*	Assurance *Evidence that the controls are effectively implemented*	Action Required (with timescale to complete) *Gaps in controls or assurance*
								Clinical dashboard Review Group chaired by Deputy Chief Nurse and Director of Quality reviews indicators from Clinical Dashboard External - Monthly nursing workforce report to NHSI regarding care hours per patient per day for inpatient wards. Safe staffing report submitted annually to Public Board meeting	Approve and Publish new End of Life Care Strategy - **Q1 20/21** Implementation of End of Life Care quality standards - **Q1 20/21** Establish School of Nursing - **Q2 20/21** Development of international nurse recruitment model with Birmingham and Solihull STP - **On-going** Implementation of actions from CQC Inspection - **On-going**