Appendix A Board Assurance Framework - Quarter 1 2021/22 *** 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*
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 funding leading to reduced 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	Following the emergency financial regime introduced at the start of 2020/21, a revised regime is now in place for months 7 to 12. Whilst based around a block payment, it is anticipated that an adjustment will be made on the basis of delivery against nationally prescribed activity levels. The calculation of the block payment value differs to the forecast expenditure of the Trust in addition to the Trust forecasting that full delivery against the activity targets is unlikely. As such income is forecast to be lower than anticipated costs and a financial clawback is expected due to under-performance against activity targets. This risk will be exacerbated 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,	CFO	**20** **(5x4)**	**9** **(3x3)**	**6** **(2x3)**	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	Trust Interim Financial Plan approved by Board in April 2020 Trust approved Financial Plan in October 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	Support Internal Auditors with on-going scrutiny and assurance - **Ongoing** Review of underlying financial position to inform financial plan for H2 and 2022/23 - **Ongoing** Development of efficiency programmes both internally and at system level to meet waste reduction targets set by NHSE&I - **Ongoing**
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 6 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)**	**9** **(3x3)**	**6** **(2x3)**	Trust 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:** Revised Trust financial plan for months 1-6, 2021/22 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 All external capital funding drawn to the maximum available Sales ledgers queries addressed and invoices paid **External:** Monthly financial return for cash balance and cash forecasts reported to NHSI	Ensure contracts/agreements are in place ahead of invoicing to minimise disputes and link in outstanding debts from 2020/21associated with purchase - **Ongoing**
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: * Potential for unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progression and poor outcomes; including excess deaths. *Increasing number and severity of incidents and claims. *Financial delivery of CIP and use of resources, productivity and efficiency * Patient experience may fall below the required standards which may lead to an increasing number of complaints * Regulatory action may lead to loss of licence or service and constraints in Board decision making * Reputational damage may arise as a result of adverse media coverage * 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: * Prolonged period of severely reduced activity due to Covid19 resulting in waiting list backlog and excessive patient waits for treatment. * 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 & added challenges of managing hot & cold patient flows through the hospitals * 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)**	**Quarterly:** Divisional Performance Management Framework which includes quarterly performance reviews. **Monthly**: Chief Operating Officer's group (COOG) monitor and improve performance across the Trust. A pefomrance report is produced by the director of Operational Performance which includes. *ED Standards/Bed Capacity *Cancer Tracking *RTT Management inc diagnostics revised Access Policy for C19 Prioritisation of Cancer & Elective wait ing lists 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. **Weekly:** Daily tactical call chaired by COO/DCOO Friday Operational Team meeting chaired by COO Monday, Wednesday, Friday - BSOL Operational Delivery Group on Elective Backlog Reduction, chaired by UHB COO **Daily** Theatre Prioritsation meeting chaired by Medical Director for Operations. This clinically-led UHB elective prioritisation meeting to ensure best use of available theatre lists (both internal and in Independent Sector). Representation from UHB Head of Out of Hospital Services, UHB Discharge Hubs, BCHC/BCC Integrated Hubs - all patients listed/ to be referred discussed and allocated into P2 pathway. Stranded P1 patients discussed and allocate dinto P2 where P1 non progressing - swabbing satus of all referred patients. This includes out of Birmingham patients where local authority are not placing. None Brimingham patienst moving into Birmingham P2 beds Ongoing process for clinical prioritisation of elective patients in line with regional and national guidelines. Patient health status review process in place for long-waiting, clinically low priority patients, underpinned by framework for escalation and clincial review.	**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 operational response to the COVID-19 pandemic. These include the continuation of a site 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. Collaborative demand and capacity modelling has been 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. Monitoring figures for ED performance and capacity via bed meetings and dashboards. Short, medium and long term plans. **External:** NHSI/CCG/ CQCand UHB assurance meetings BSOL Backlog Reduction Operational Delivery Group	Governance team to ensure all specialty specific risks are captured locally with MDs. To Provide summary for COOG meeting- **Ongoing** Continue to actively monitor the delivery of recovery action plans - **Ongoing** Specific specialties subject to targeted support in further developing and delivering improvement action plans - **Ongoing** Informatics and IT support to align and amend reporting arrangements from the multiple systems. there are plans to bring much of the organisational reporting together following the implementation of the new Patient Access System, which is scheduled for October 2020 - **Ongoing** System wide theatre capacity plan to be agreed for delviery in Q1 based on agreed demand and capacity model outputs - Complete - **Q3 plan being developed.** Trust-wide agreed process to be established for the review of potential harm of Covid-related delays to treatment. **Ongoing** -Transfer of trauma and othopaedic ambulatory service and fractured neck of femur service to BHH site - **July 21** -Optimisation of acute/emergency pathways - **Ongoing** -Open2 additional medical wards reopened at Solihull - **July 21** - Maximise the use of theatres and restarting elective orthopaedic surgery at solihull - **Ongoing** -Outsourcing of Cardic and Orthopaedic surgery - **tbc** - Insourcing of theatre staff - **Ongoing** - Expansion of bed base (c150 beds) across UHB to support emeregency and elective flow - **Dec 21**

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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.	COOHS	**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 EICT home based health and social care community team rolled out across Birmingham.The team includes representation from the Trust's community teams supporting GHH and BHH. * Regular meetings with senior managers from South Staffordshire focusing on D2A action plans, performance and developments to deliver improvement. * COOHS is a member of the Birmingham Early Intervention Steering Group, a meeting comprising leads from all providers focusing the system performance. * BHH, GHH, & SHH operational representatives are members of Solihull Ageing Welll work programme with SMBC and BSOL CCG on system working to reduce delays. * 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. * Discharge to Assess (D2A) 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. * Weekly BSOL System Discharges& Care Homes Group chaired by the Chief Executive, Birmingham Community Healthcare NHS Foundation Trust to oversee plans in response to national COVID discharge guidance.	**Internal:** * Electronic tracking system in place across each acute hospital site with daily board round records for each patient and agreed actions. * Daily board round evidence from BHH, GHH and SHH sites. * Weekly D2A reports on each acute site hub are published weekly and reviewed by each team including social care. * Daily Medically Fit 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 * Solihull Together minutes * Weekly BSOL System Discharges& Care Homes Group minutes/actions. BSOL Early Intervention Steering Group minutes, Birmingham OSC Committee papers	The system response to COVID-19 is focusing on keeping MFFD numbers and length of stay to a minmum 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	DoW	**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 * Staff Health & Safety Risk assessments for vulnerable, BAME and all staff groups * Flexibility encouraged/homeworking/self rostering in place to support work life balance * Agreement reached to recruit internationally for nurses within ITU and Theatres * Continuation of Apprenticeship programme	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 * Internal Audit review (Oct 2020) of Trust recruitment processes, specifically the Right to Live and Work checks. Monlthy Provider Workforce Return (PWR) to NHSE/I	STP Workforce Planners Group to develop STP wide dashboard on progress towards Annual Plan BSOL **Ongoing** BSOL Workforce Planners meet on a monthly basis to discuss development of the workforce planning agenda, and opportunities for improvement linked to BSOL People Board priorities **Ongoing** Roll out of Oleeo Recruitment system **Q2 2021/22** Recruitment and Selection Policy and associated procedures to be drafted, consulted upon and ratified **Q2 2021/22**
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 Chief Legal Officer * Compliance with the Mental Health Act is measured * The implementation of the requirements of set out in the Private Healthcare Market Investigation Order 2014 is monitored and reported * Audits of the consent process are reported	**Internal:** Annual Governance Declaration Good Governance Institute Report Internal Audit Quarterly Divisional Performance meetings Contract review meetings Quarterly compliance reports to BoD and Audit Committee CQC external report Progress against actions reviewed regularly in conjunction with CQC relationship managers Compliance Framework reports to DCQG meetings every quarter National Audit presentation to CQMG Annual report to Clinical Quality Monitoring Group (CQMG) Health and Safety Executive Committee minutes Internal Audit report of Health & Safety Procedures within Estates HSE investigation outcome into the Trust's management of Occupational Dermatitis Information Governance Group minutes Policy Review Group minutes Exception reports to CLO Governance Group Quarterly reports to Mental Health Group Bi-annual PHIN Working Group minutes Statutory Compliance review **External:** QSIS self-declaration Annual DSP Toolkit submission	Implement actions from 2019 CQC review - **Ongoing** Implement must-do and should-do actions from 2021 CQC review - **Ongoing** Complete review of 'Compliance with the Mental Health Act 1983 (as amended 2007)' and associated procedure to be completed - **Q2 21/22** Implement improvement plans from Data Security and Protection Toolkit - **Q2 21/22**

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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	CDO	**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 21/22** Network, wireless and telephone capital milestones work programme - **Q2 21/22** Implementation of ICT improvement action plan for ISO9001 and ISO27001 to meet Statement of Applicability - **On-going** Implementation of core systems across the Trust to support delivery of care - **Q1 22/23** Review and improvement of change controls procedure for local and third party systems - **Q2 21/22** Implementation of improvements related to cyber security identified through DIONACH report - **Q1 22/23** Review and update of Business Continuity Plans - **Q3 21/22** Implementation of Internal Audit recommendations - **Q1 22/23**
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. There is a further risk in terms of the impact of changes to MHRA following the UK's exit.	CIO	**16 (4x4)**	**9 (3x3)**	**6 (3x2)**	Membership of overseas research networks Exploration of non-EU trials work and identification of novel sources of R&D activity through development of Trusted Research Environments for Data (paper presented to Investment Committee), Covid R&D activity and Cell & Gene Therapy research. Strategic alliance through Birmingham Health Partners (BHP) who continue to lobby regarding Brexit uncertainty Working with Pharma companies to provide a premium service and established Research Allocation Framework to ensure optimum efficiency within Research Trials. Tier 2 visa regime for doctors, nursing and high-tech staff	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 EU-UK Trade and Cooperation Agreement Strategic Emergency Planning Group	Monitoring of current landscape and developments - **Ongoing** Complete installation of EDGE Research IT system and develop R&D capability as Oceano and PICS rolled out across the Trust sites - **Ongoing** Lobbying of decision makers through Birmingham Health Partners - **Ongoing** Lobbying through the Association of UK University Hospitals, and attendance at their Briefing Sessions - **Ongoing** Develop close working links with the Association of British Healthcare Industries (ABHI) - **Ongoing**
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.	CFO	**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 resonsible for fire safety, asbestos management, medical gases and other regulated activity. Governance structure and processess 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 imlemented 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 - **Ongoing** Estate Strategy for all Trust sites to be approved -**Ongoing** Implementation of Estates workforce review recommendations - **Q4 21/22** Increase of electrical capacity to BHH site through planned extension of infrastructure - **Q4 21/2**2 Extension to existing energy centre (hot water and heating) at BHH - **Q4 21/22** Completion of ACAD Build - **April 2022** Site plans and subsequent Six Facet Property Condition Survey for Heritage Site - **Q3 21/22** Evaluation of technical recommendations to inform plans for remedial works and PFP improvements - **Ongoing** Development of offsite community facilities (Arden Cross, University and New Street stations) - **Ongoing**

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SR1/19	**Prolonged and/or substantial failure to deliver standards of nursing and midwifery care** As a result of inconsistencies in nursing and midwifery care relating to: -Safeguarding Patients -Falls Prevention and Management -Infection Prevention and Control -Tissue Viability -Nutrition and Hydration -Patient Experience -End of Life Care and Bereavement -Vulnerable Patients and in midwifery care relating to: -Initial assessment and escalation of patients with complex needs -Care plans and continuity -Screening 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 ongoing 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 and midwifery 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 and midwifery staff -Recognition and response to patients with complex needs and continuity of care -Individual substandard practice of registered health professionals	CN	**20 (5x4)**	**12 (3x4)**	**6 (2x3)**	National and local policies, procedures and guidelines detail the required standards and practice for nursing and midwifery care in each specialist area Specialist nursing and midwifery teams that support ongoing monitoring, scrutiny and improvement of standards of care Adherence to Safe staffing models provides nationally directed ratios of staff to patients Corporate Induction and ongoing mandatory training for all staff outlines required standards of practice and care Specialty training provides specific support for nursing and midwifery staff Ward level quality dashboards that provide real time data in relation to standards of care Nursing metrics and scheduled audit 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. National accreditations and certifications based on the attainment of standards such as Baby Friendly Initiative and CNST Maternity Incentive Scheme	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 In addition a 1/4 paper is submitted from Maternity Services The specialist steering groups monitor compliance and performance with nursing standards, ensure issues/incidents are recognised, acted upon, reported and lessons are learnt and shared. Specialty and Divisional Quality and Safety Groups review and scrutinise compliance with midwifery standards and performance at local level Chief Nurse Workforce Group receives nursing and midwifery reports and provides assurance to the Trust's Strategic Workforce Group regarding workforce plans 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. 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	Nursing Actions •Develop and Implement process to provide assurance that staff completing insertion, management and position checking of NG tubes are competent/credentialed. - **Q2 21/22** •Develop and implement education programmes for medical, nursing and therapy staff for NG tubes - **Q2 21/22** •Develop PICS documentation for insertion, placement checking and care of NG tubes - **Q2 21/22** • Revised SOP for the Assessment of 16-18 yr olds to be implemented – **Q2 21/22** •Risk assessments for 16 and 17 year olds to be hosted on PICS - **Q2 21/22** • Agree funding for the Looked After Children Service – **Q2 21/22** • Implement web based referral system for use across BHH,SHH and GHH – Q2 21/22 • New tiered training package on MCA and BI and related to the Consent Policy to be launched. – **Q2 21/22** Develop and implement new interventions to reduce the transmission of Covid-19 - **Ongoing** Development of a new Covid-19 dashboard with Informatics to provide real time monitoring of the Trust's Covid-19 status - **Ongoing** •Develop new Moodle training and competency assessments for all staff in relation to Tissue Viability prevention and management - **Q2 21/22** •Training and Education for all staff re updated EOLC standards - **Q2 21/22** •Develop new standards for Inclusion and Wellbeing - **Q2 21/22** •Development of international nurse recruitment model with Birmingham and Solihull STP - **Ongoing** •Implementation of actions from CQC Inspection - **Ongoing** Midwifery Actions • Review of Midwifery Support Worker (MSW) role - **Ongoing** *Implementation of Better Births continuity of care pathway - **Ongoing** **For details of further midwifery/maternity actions please refer to risk SR1/20**
SR1/20	**Ability to provide the highest quality of treatment and care in maternity services** A failure to maintain and improve standards in maternity treatment and care could result in: * Avoidable or increased levels of harm to patients * An increasing level of remedial treatment and care leading to an increased length of stay and poorer outcomes * An increase in the number and severity of legal claims * Additional complications that may delay discharge or transfer of care * Negative impact on our ability to recruit and retain the highest calibre of staff from the UK and around the world * In severe or ongoing cases a regulator may intervene which may lead to constraints in decision making by Board * Failure to meet operational performance targets * Adverse media coverage may lead to reputational damage.	Maternity services includes pathways managed by obstetrics, midwifery, early pregnancy and neonates. Standards are specified in national and locally 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: * Inability to recruit and retain the right numbers and skill mix of workforce * Inconsistencies in clinical pathways and clarity regarding the process and continuity of care *Timeliness and quality of decision making and escalation * Incomplete training and competencies * Inconsistent communications across disciplines * Inconsistencies in governance arrangements * Individual substandard and variable practice of registered health professionals * Failure to learn from incidents and make sustainable improvements * Demand exceeds capacity to deliver services * Quality and quantity of facilities and estate * Unwillingness to raise concerns * Reliability of clinical IT systems and quality of data to support decision making and reporting	CN	**25 (5x5)**	**12 (3x4)**	**8 (2x4)**	* Internal policies, procedures and guidelines detail the required standards and practice for specialties in maternity care * Divisional and Specialty Management Teams that support ongoing monitoring, scrutiny and improvement of treatment and care through governance, group and committee structures. * Corporate Induction and ongoing mandatory and specialty training for all staff outlines required standards of practice and care. * Annual revalidation, appraisal and personal development plans for registered professionals * Reporting and Management of Incidents via Datix provides a route for all staff to raise concerns * Maternity Services are required to implement a range of standards based on ongoing reviews and improvement priorities at a national level. Amongst these is the national Maternity Transformation Programme which seeks improvement through collaborative working in the regional Local Maternity System (LMS). This includes • The appointment of Maternity Safety Champions - a central role in ensuring that mothers and babies continue to receive the safest care possible in line with the National Ambition. • Implementation of ATAIN programme to improve neonatal care . • Implementation of Saving Babies Lives Care Bundle - to reduce the risk of perinatal mortality through the routine implementation of 5 elements of care • Compliance with the Maternity Safety Scheme aspect of the Clinical Negligence Scheme for Trusts (CNST) operated by NHS Resolution • Reporting of maternity incidents to HSIB • Submissions of data to national audits, reviews and surveys * A Maternity Safety Improvement Plan which sets out the work required in the next 3-5 years to ensure elements of leadership, best practice, teams, data and innovation are effectively implemented. * Implementation of the principles in the Continuity of Carer model in support of the outcomes required by Better Births.	* The Committee for Clinical Quality (CCQ) is a Board level assurance and review committee which receives reports from the Chief Nurse's Care Quality Group (CQG) and the Chief Medical Officer's Clinical Quality Monitoring Group (CQMG). * CQG is chaired by the Chief Nurse and has responsibility to review submissions from a range of specialty steering groups including scheduled Maternity Safety reports. * CQMG is chaired by the Medical Director and has the responsibility to review the key indicators for Clinical Quality and report exceptions. * The Nursing, Midwifery and Medical Workforce Groups report to Trust's Strategic Workforce Group regarding workforce plans and progress. This includes ongoing compliance with the national staff/patient ratios. * Bi-weekly board level Safety Production Meetings * The Division 6 Management team receive monthly reports relating to performance and outcomes from the Specialties under their remit. * Specialty Quality Meetings and Operational Performance meetings review local activity, receiving updates from their governance and clinical service leads. The specialty teams then provide assurance to the Divisional Team. with reports include: • Saving Babies Lives – Quarterly • Maternity Safety Report – Monthly • Bespoke Maternity Safety Improvement Plan - quartely • (MAtNeoSip) – Quarterly • Maternity Dashboard Report – Monthly • ATAIN – Quarterly Report • Divisional Management reports including Director's updates, Cancer Assurance, Finance, HR, Governance, Safeguarding and individual Specialties • Specialty Reports including Maternity Dashboard, Patient Experience, Guideline updates, Staffing and Training , Audit findings, matter for Escalation and external reporting (PMRT, HSIB, RCOG, NHSR,PHE, MBRRACE, NNAP)	Development of new Maternity Services Strategy - **Q2 21/22** Review and update of specialty guidelines - **Ongoing** Implementation of Trust's Maternity Safety Improvement Plan - **Ongoing** Implementation of MatNeoSip Improvement Plan - **Ongoing** Submission of CNST evidence - **July 2021** Implementation of actions originating from NHSI Maternity Safety Support Programme, including: • Review of training needs analysis (TNA) for specialties - **Q2 21/22** • Development of action plan regarding appraisal compliance and assurance - **Q2 21/22** • Review of Maternity services business plan- **Q2 21/22** Implementation of urgent actions from Ockenden review **Q2 21/22** Gap analysis for longer term actions from Ockenden review - **Q2 21/22** Implementation of the Prince of Wales estates improvment plan - **Ongoing**