Ashford and St. Peter's Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS
7th DECEMBER 2022

AGENDA ITEM NUMBER	6.1
TITLE OF PAPER	Chief Executive's Assurance Report (including Board Assurance Framework)
EXECUTIVE SUMMARY	
	This is my second report as Chief Executive since arriving in May 2022 and was first presented to the Trust Board on 1st December 2022. In this report I focus on the core business of the organisation and how I lead on the work through my personal leadership and through the objectives and efforts of Executive Directors and their teams. The work in the report is presented as per corporate strategic objective format of Quality of care, Modern Healthcare, People, Digital and Collaboration. The purpose of the paper is to inform, give assurance and bring together the work of the trust in a high-level summative report which demonstrates the breadth of the work, synergies, interdependencies and how any risks related to the work are represented within the Board Assurance Framework. An update on the Trust financial position is also included and, finally, the Board Assurance Framework (BAF) is included at Appendix 1. The BAF has now become a separate report to Board and is included here for information. This report continues to be iterative, and I welcome your feedback on its content and format.
PRESENTED BY	Julie Smith, Chief Executive
DATE	November 2022
BOARD ACTION	The Council is asked to RECEIVE the report

1. Introduction

This paper represents the key items of work and opportunities ongoing in the organisation and wider place and system, led by the CEO and the Executive team. The items span the divisions with updates on a number of maternity and neonatal reports, the work on the Main Effort improving our response to urgent and emergency care, and the Surrey Heartlands Elective Centre led by Cathy Parsons supported by the surgical divisions.

There are some areas of concern to note regarding the potential for industrial action, but there is a good emergency plan in place.

The update includes policy updates regarding the NHSE operating framework and the governance refresh that was commenced following the Deliottes well led review and 'brainstromed' at our recent away day. The well led work includes developing opportunities to meet with clinical colleagues and engage them in the leadership work of the organisation. The consultant /executive meetings will provide this effective forum going forward and the early signs are promising regarding consultants feedback.

Surrey Safe Care continues to feature in this report but there are some key changes reflected as we reach the 6 month mark post implementation.

Finally and particulary in response to a fair challenge at last month's board there is an update on NWSurrey Alliance and feedback regarding the recent place workshop and next steps.

2. Strategic Objectives

2.1 Quality of Care

Maternity Update:

Kirkup Report - The report into the failings at East Kent hospitals maternity services was published on 19th October 2022. This report was challenging to read and has highlighted many of the same issues as previous maternity investigation reports. This report has a strong focus on how the board identify and listen to the signals that there may be concerns in the maternity services and what the board can do to support improvement. Trusts are mandated to discuss the report within its Open Board meeting to identify actions we must take to ensure we can 'read these signals.' There will also be actions at a national level work to amalgamate recommendations from the recent reports and clarify data which will support Trust Boards.

The Trust has commenced an overarching comprehensive review of the findings alongside the requirement of the Ockenden report and the recent publication of MBRRACE 2020 data to enable a full triangulation and robust and meaningful response.

Ockenden – Progress has been made with the initial seven immediate and essential actions (Immediate Essential Actions) set out in the Ockenden report. Risk assessment of each antenatal contact has been implemented with development of website pages and the birth choices guideline and patient leaflet still to be achieved. Benchmarking has taken place against the final Ockenden report with identified actions shared and this will be monitored in the Ockenden Oversight group chaired by the Chief Nurse and through reporting to Quality of Care committee and trust board. The Trust has also now received the report from the Ockenden insight visit undertaken in July 2022 and the recommendations from this will also be monitored by the Quality of Care Committee.

Care Quality Commission (CCQ) and Clinical Negligence Scheme Trusts (CNST) [1] preparations - In addition to the above, the Women's Health and Paediatrics division has been working hard to prepare for an expected CQC visit with action plans for all clinical areas and a programme of works. The department are also working hard to achieve all ten safety actions required for the forthcoming CNST submission. Areas of concern have been identified and the Trust evidence is currently under review by the Local Midwifery Neonatal Service[2]. The Trust's submission for CNST is due on 2nd February 2022.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE) - ASPH has been rated as an outlier for neonatal death and stillbirth, most recently in the MBRRACE 2020 perinatal surveillance report published in October this year. This is a different outcome than the Trust has seen through other methods of capturing neonatal mortality data, which has demonstrated excellent survival rates for our population of preterm infants in particular. Additionally for the same period of time ASPH has been identified as the number one neonatal unit in the country for treatment effect on the outcome of chronic lung disease or death. Subsequently the WHP divisional team have been working through the evidence to understand how this report can appear to suggest the contrary.

The data used in this MBRRACE process undergoes some validation and stabilisation during which we have been able to establish, with MBRRACE that the data is skewed to some degree given our unique position of having a level 3 NICU in a district general hospital with a relatively lower birth rate. As such comparison with other trusts can be problematic and appear worse as a consequence. MBRRACE are aware of this and we continue to work with them to help inform the reporting process.

That said, we remain concerned regarding our RAG status and have requested a look back at the mortality reviews for 2020 to ensure actions have been completed and the same issues are not recurring. It is important to note that the above explanations are mainly focussed around neonatal deaths. Neonatal death is an outcome of antenatal, perinatal, and neonatal care. Whilst we are assured about our neonatal care from other sources, we must continue to review perinatal management and decision making. This is equally true when reviewing the stillbirth rate. A lot of positive changes have been implemented since 2019 regarding perinatal management of prematurity and fetal monitoring at all gestations; in part due to incentives from Saving Babies Lives and CNST for example; as well as regional guidance; and increased recruitment to an obstetric workforce that has specialist skills and interest in this area.

Industrial action – business continuity planning:

Several NHS unions are currently planning industrial action over a dispute with the Government regarding national NHS pay which will impact the operational service delivery and workforce across a number of professional staff groups.

In preparation, a Trust Industrial Action committee is meeting weekly and includes key senior staff representing clinical and non-clinical managers/clinicians. The workforce response team is also actively preparing to support the organisation in the event that industrial action is mandated. This will include but is not limited to sitrep reporting, access to advice via drop-in sessions and dedicated telephone support, guidance on redeployment, and temporary staffing i.e. Bank/agency backfill. There is also regular liaison with trade unions.

[1] Clinical Negligence Scheme for Trusts which supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST.

[2] Local Maternity and Neonatal Systems (LMNS) were established across the country to provide support to maternity units to achieve more personalised, safer care and improved continuity of care.

Once we are aware of the key groups affected (including any proposed dates) we will be able to agree set-up of the Hospital Control Strike Action team. This team (made up of divisional representation) will be expected to have oversight of their respective core critical business and will be expected to be able to report into Hospital Control upon staff numbers impacted by the strike action and what services they plan to continue or defer or cancel as a result. This information will feed into a wider system sitrep reporting template for wider system understanding of impacts.

In early November we were advised of the outcome of the one of the union ballots: Royal College of Nursing (RCN), and that the ballot returns for the Trust did not achieve the threshold required to mandate for industrial action. We do, however, acknowledge the strength of feeling that we know exists regarding pay and conditions and will continue to work closely with the RCN and others to ensure the voice of nurses are heard and to do all we can within our own control to ensure we respond to the concerns people have.

2.2 People

Engagement with Consultant workforce:

I wrote in September about my ambition to develop a regular forum to meet with consultant colleagues and in October we held our inaugural Consultant-Executive meeting. It was an informal meeting scheduled after work in the EDU kitchen with refreshments, but was also available online for those who could not join in person. The meeting was very well attended with over 80 consultant colleagues present. The Executive team shared updates followed by ample time for debate. Following the meeting, many consultant colleagues responded positively to a request for feedback on how we can best utilise the forum going forward. Using this feedback we have now formalised the meeting as a bi-monthly forum which will remain both virtual and face to face and at least one in three meetings taking place at Ashford Hospital.

It is anticipated that this regular forum will provide opportunities for consultant colleagues to meet with executives, to discuss, debate and inform key workstreams to ensure the clinical voice is heard and the work of the organisation is informed and shaped by clinicians. The hope is this will promote better joint working, improve accountability and the delivery of results.

Alongside the consultant meeting, we have also now developed a clinical executive, whereby the executive and key clinical leaders come together on a monthly basis to discuss key issues and inform the trust strategy.

Both meetings are a formal part of the trust management and governance framework and are in line with the recent well led review and resultant recommendations.

2.3 Modern Healthcare

Main effort:

The Main Effort (ME) continues to deliver positive results. It’s approach and framework continue to gain traction and it is becoming more widely known and understood both inside and outside the Trust. The iterative approach adopted has meant that success is building on success. The ME scope and remit continues to grow as new opportunities are identified. The steering group are working hard to deliver the remit - to ensure that only those that will benefit from our care reside with us. At its heart the ME is becoming the embodiment of the ‘right care, in the right place, at the right time’. There is still a long way to go but as more people become involved, more opportunities are created for us to evolve the way care is delivered.

The ME has been iterative and 'organic' but distinct phases have become clear:

Phase 1: (*complete*) saw the alignment of a number of opportunities. The ward refurbishment programme needed to happen but coincided with increased bed capacity within the community. The ME steering group coordinated this activity resulting in nearly 60 beds being realigned.

Phase 2 (*ongoing*) focuses on Urgent Care and its pathways. Significant work has taken place both within the Urgent Care Division and cross Divisionally. The creation of a 'navigator' role in ED has proved incredibly successful and is still evolving. The challenge is now mainly logistical (optimal location, staying warm in the winter when next to an open door etc). The Divisional leadership team ran a reset period over a number of weeks which has experimented with different ways of doing business. This has revealed some new ways of working and they will now focus on the admitted and non-admitted pathways.

On 2 November the Trust was visited by the Emergency Care Improvement Support Team (ECIST). The team of three spent a day with the Urgent Care Division visiting ED, AECU, CAU, plus Maple and Cherry Wards. We are still awaiting 'formal' feedback but the feedback provided on the day was incredibly positive. The team were very impressed with the Main Effort work and were positive about its aspirations and approach. It was cited as being unique (in a positive way) and they had not seen any other Trust attempting such a fresh approach. They were particularly complimentary about the leadership it is demonstrating and the fact it has a genuine aspiration to learn and improve. The team have agreed and are keen to work with us further. They would like to assist but also learn from us. This was an incredibly positive visit providing external reassurance that the approach we are adopting is not only novel, but one that has real potential.

Phase 3 (*just commenced*) is a push to quickly capitalise on further opportunities for the reconfiguration and realignment of beds. This will be better for patients and assist as winter approaches. As with phase 1, opportunities have been identified that can be utilised, but timelines are tight. This phase will focus on surgery and palliative care, plus opportunities in the community that will allow us to merge and reconfigure wards.

This has been an incredibly successful period for the Main Effort. It really has created a vehicle for change and is proving incredibly useful as a way of getting teams to trial and experiment with different ways of working. It conducted a review recently and the following were identified as lessons learnt so far:

- The iterative process works. Better a good plan now than a great plan that is too late.
- Using a 'trial' is a good way of getting the team to experiment with different ways of working.
- The importance of articulating the 'what and the why', letting the team own the 'how'.
- If someone is close enough to identify a problem, they can probably identify a solution. We must encourage ownership.
- The utility of the RACI (Responsible, Accountable, Consulted, Informed) matrix.
- Leadership: The ME has called for a much more direct and personal leadership approach.

The ME work is starting to demonstrate some real and sustained improvements in KPIs. For example, the 4 hour performance, ASPH is one of the top 5 performing trusts within the SE region. Stranded patient numbers (patients who continue to reside within the organisation over 14 and 21 days) has improved between 10-14% leading to the release of bed days. Lastly, between 4-11 patients who do not meet the criteria to admit have been successfully and safely discharged on a daily basis from the Clinical Decisions Unit (CDU), rather than being admitted.

Surrey Heartlands Elective Centre:

Following NHSE approval of funding in September, work has progressed on the new Elective Centre at Ashford. Four new theatres will enhance the Ashford theatre complex. Workshops are in place to engage with staff across Surrey Heartlands on the development and mobilisation of this elective unit.

Aligned to this work is an opportunity to cease hiring the Vanguard Theatres for Ophthalmology. Work has commenced with the specialities and divisional teams to consider options for creating additional capacity to utilise our existing theatres in the most efficient way possible in advance of the additional new build theatres coming on stream.

The elective centre will build on established enhanced surgical pathways that separate Elective and Emergency work providing solely elective surgery and there are opportunities for Ashford and St Peter's patients and those from other Surrey Heartlands providers to benefit from this.

We aim to extend the theatre working day through increased theatre capacity; both physically with the new build, and internally with take up of the current down-time in theatres.

Increased internal capacity will also enable the Elective Centre to take on elective surgical patients from other parts of the region alongside the extra new capacity coming from the new build theatres. This work will be governed through the Surrey Heartlands Integrated Care Provider Collaborative Board and the Integrated Care Board.

Two collaborate events will take place in November and December with over 60 colleagues from across Surrey Heartlands meeting to discuss the vison for the Elective Centre. These will be the first of several workshops where clinicians, senior leaders and patients from all of the three Trusts involved will have the opportunity to engage and input their thoughts and ideas as the project plans are formed. This involvement at an early stage will enable collective actions to be agreed.

Detailed structural drawings have now been created by the Estates Team architects and are in the final stages of sign off. Based on current planning times, the new structure for the four new theatres will aim to be in place by mid-2023.

The Surrey Heartlands Elective Centre will be part of the Get It Right First Time (GIRFT) Surgical Hub Accreditation process and will work closely with colleagues from the GIRFT teams to ensure we create a service that is at accreditation level; we have put forward our elective centre to be a pilot site for the GIRFT accreditation process which will put us on good standing for progress and learning.

Governance/well led review:

Following the external Well Led Governance review undertaken in March 2022, a number of recommendations for improvement were made and an action plan developed in response. There has been good progress made against the action plan as well as with a wider and more systematic governance transformation project which encompasses the Well Led action plan. This is a more detailed project, with extended scope defined by four phases to be largely completed by Quarter 1, 2023/24. The project aim is to review and refresh the Trust's governance framework in a more comprehensive way. In a nutshell, the governance transformation project will aim to deliver:

- Better quality discussions at Board and sub-committee level with streamlined board agendas allowing more time for debate.
- Refined meeting structure - with fewer sub-committee meetings.

- Streamlined reporting requirements and removing duplication with simplified reporting requirements to Board.
- Improved effectiveness and impact of Trust Board and committees with more time to prepare between sub-committee meetings and Board.
- An enhanced role of Clinical Divisional triumvirates and the Consultant body through refreshed mechanisms for engagement and the strengthened governance framework.
- Improved read across and information flows between committees.

NHSE Operating framework:

On 12 October NHS England (NHSE) published its new operating framework. NHS England's new operating framework sets out how the NHS will operate in the new statutory framework created by the Health and Care Act 2022. It reflects the formal establishment of integrated care systems (ICSs) in July this year and the need to change the way NHS England works and behaves in this new system architecture. It also reflects the needs of an expanding organisation, which will bring NHSE together with Health Education England (HEE) and NHS Digital. The new operating framework has four core foundations, which define NHSE's:

- Purpose - Which it has defined as "To lead the NHS in England to deliver high-quality services for all."
- Areas of value – It will focus on setting direction, allocating resources, ensuring accountability, supporting people, enabling improvement and transformation, and delivering services.
- Leadership behaviours and accountabilities.
- Medium-term priorities and long-term aims.

NHS Providers welcomed the document stating that is clearly set out how the NHS will function and be managed going forward. They further commented it sets out the roles of the ICBs and providers and their relationship.

2.4 Digital

Surrey Safe Care:

As we pass six months since the go-live of Surrey Safe Care (SSC) and look ahead to the future transformation potential it offers, Simon Marshall, Director of Finance and Information has stepped back from his role as overarching SRO for the programme. To reflect this significant change Simon will change his title to Chief Finance Officer. James Thomas, Chief Operating Officer continues to lead the ongoing operational stabilisation and recovery work, supported by the Director of Digital, Chief Clinical Information Officer and many others to ensure that SSC functions at the highest level to support our operational and clinical practices. Tom Smerdon, Director of Strategy and Sustainability will now take forward the benefits realisation programme, focused on achieving the ambitious transformational improvements that were part of the initial vision for Surrey Safe Care. The benefits realisation work will be reported and monitored through the digital committee as a key enabling strategy work stream, as part of the overarching digital strategy for the organisation.

2.5 Collaborate

NW Surrey Alliance: workshop output and next steps:

At the end of September the North West Surrey Alliance brought together over 200 colleagues across two days to develop key areas of our strategy going forwards. These strategy sessions included chief executives, executives, service leaders, frontline clinical teams, local government offices, social care and voluntary sector leaders, representing all 11 Alliance partners and over 20 partner organisations.

Key elements of the Alliance's future strategic development, created and endorsed, through these events included:

- Defining ten clear 'Neighbourhood' footprints based on real areas, towns and community that people would naturally recognise and identify with. We will configure integrated teams across organisations and professional disciplines within these Neighbourhoods to provide holistic care to people, particularly those at high risk and with multiple needs.
- Bringing together specialist services and diagnostic infrastructure at key sites in our 4 Boroughs to support people who need more complex care, allowing that to happen in the community.
- Integrating all of our urgent care provision across organisations to deliver a clear, robust offering for people as a genuine alternative to presenting at A&E.

In consolidating the fundamental strands of our strategy, the Alliance Board approved the development of a number of business units across the partnership that will bring these interrelated services together as a clear, single offer to patients and staff. The detail of these business units will be scoped by key service leaders in the coming weeks with transformation realised in the final quarter of this financial year and across 2023/24.

3. Finance update

2022/23 Financial Position - Month 7

The plan figures presented in this report for month 7 2022/23 reflect those that will be monitored by NHSI based on the final 2022/23 plan submission on 20th June 2022.

	Plan to 31 March 2023	Mth 7 YTD Plan	Mth 7 YTD Actual	Mth 7 YTD Variance	Forecast
Income	397,484	229,653	233,416	3,763	402,515
Pay	(254,769)	(150,137)	(155,924)	(5,787)	(262,700)
Non-Pay	(135,995)	(80,355)	(80,355)	(0)	(134,260)
EBITDA	6,720	(839)	(2,863)	(2,024)	5,555
EBITDA %	*1.7%*	*-0.4%*	*-1.2%*		*1.4%*
Below the Line	(18,820)	(10,872)	(10,451)	421	(17,655)
NHSI Control Total Surplus	**(12,100)**	**(11,711)**	**(13,314)**	**(1,603)**	**(12,100)**
Excluded from Control Total					
Impairments	0	0	0	0	0
Donated/Granted Income	394	294	140	(154)	394
Donated/Granted Depreciation	(486)	(281)	(281)	0	(486)
Overall (Deficit)/Surplus	**(12,192)**	**(11,698)**	**(13,455)**	**(1,757)**	**(12,192)**

During September and October the Trust made payments for pay arrears back to April 2022 under the agreed national pay awards. The cost of the pay award exceeded the income that was

included in the initial tariff uplift and plans, however the Trust received an additional block contract income increase from September to fund this extra cost. At present the Trust has not amended its plans for this increased income/pay cost - this is estimated at c£3.2m YTD. From November the reversal of the additional NI levy will see a relatively small reduction in pay and income - this has been built into the forecast.

The Trust is reporting a position at M7 YTD of a deficit of £13.3m on an NHSI control total basis, which is £1.6m adverse to the NHSI plan. This is on the basis of accounting for 100% of the planned year to date Elective Recovery Fund (ERF) income of £8.2m. The ERF position is one being held by Surrey Heartlands organisations on the basis that ERF recovery over the year as a whole is being forecast. Nationally ICB's have been told to assume no ERF recovery in H1 or H2, although this remains to be confirmed as the final NHSE decision.

The main variances are:

(i) income - £3.8m excess income of which £3.2m relates to additional (unplanned) contract income to cover higher pay awards;

(ii) pay - £5.8m over budget - £3.2m covered by additional income above and £2.6m other; and

(iii) non-pay - now on plan having been underspending in prior months.

CIP delivery is behind plan at 31st October 2022 by £1.7m, with work continuing to improve the capture and reporting of data. Overall the current projection is that the overall plan will be £1.1m short.

In terms of the full year finance forecast, the Trust, along with system partners, continues to report that the plan will be met, although this is increasingly challenged.

The Finance Score is reported as a 3 year to date due to the deficit position.

The capital plan reported here, along with the monthly phasing, reflects the Board approved plan. At 31st October 2022 the capital spend was £8.2m against a YTD plan of £10.2m. The Trust has received notification that it will receive various PDC funding allocations in 2022/23.

Cash balances remained high at £70.0m.

Appendix 1

1. Board Assurance Framework (Strategic Risks)

The current risk profile is presented below following consideration at Board sub-committees. There are currently 17 strategic risks on the BAF (detailed risks at Appendix 1) each are aligned to a strategic objective and oversight of the risks and the associated KPIs is undertaken by each Board sub-committee (Appendix 2). The current scores for the strategic risks and tolerable or 'target' risk scores are summarised in Fig 1 & 2:

Fig 1: Strategic Risk Map

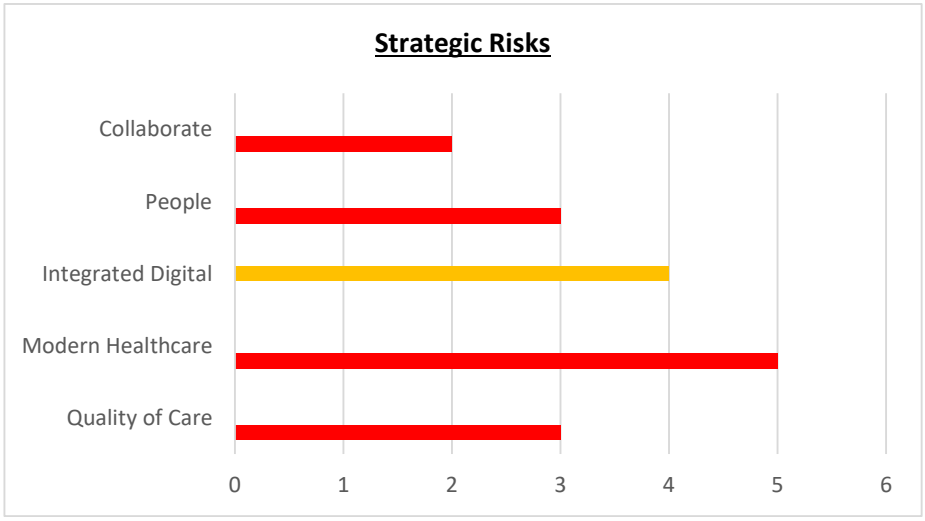
	Likelihood				
Impact	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5 Cata-strophic					
4 Major			**2**	**6**	**7**
3 Moderate			**1**	**1**	
2 Minor					
1 Negligible					

Fig 2: Tolerable Risk Map

	Likelihood				
Impact	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5 Cata-strophic					
4 Major					
3 Moderate		**6**	**6**		
2 Minor		**5**			
1 Negligible					

The Trust's current risk profile continues to be significantly changed from its position in March 2020 prior to the Covid pandemic. It is accepted, that because of the current operating environment, several strategic risks may continue to score more highly. The current risk scores by strategic objective are detailed in Fig 3.

Fig 3: Risk scores by strategic objective



BAF Overview

	Risk	Initial Rating	Post mitigation				Rationale for change	Risk Appetite Level
			Proximity	March 2020	Current Score	Direction		
1.Quality of Care								
1.1	Inability to deliver against key Quality Improvement Priorities and thereby reduce the incidence of repeated and/or avoidable harm to patients from medication errors, episodes of poor care, and avoidable mortality, due to insufficient capacity and capability.		Imminent	16	L5x C4 (20)	⇔	No change to risk score proposed.	Low ⇔
1.1a	Inability to achieve the North Star objective to end health and care acquired infections (and associated harm) for the team, patients, and the community, due to insufficient capacity and capability.		Med		L4xC4 (16)	⇔	No change to risk score proposed.	Low ⇔
1.2	Inability to improve and achieve outstanding patient experience, through an inability to harness and optimise learning from patient and family feedback, due to insufficient capacity and capability.		Med	20	L4 x C4 (16)	⇔	No change to risk score proposed.	Low ⇔
2. Modern Healthcare								
2.1	Inability to live within the financial framework allocations due to emergency activity pressures, combined with the requirements to restore elective work, undertake or outsource additional activity, & given existing staffing constraints.		Med	12	L5 x C4 (20)	⇔	No change to risk score proposed.	Moderate ⇔
2.2	A failure to maintain the Trust's physical environment and clinical infrastructure, may lead to clinical pathway difficulties, deteriorating		Long	9	L5x C4 (20)	⇔	No change to risk score proposed.	High

	patient and staff experience, patient safety, and health and safety risks.							⇔
2.3	A failure to deliver constitutional and operational targets leading to increased patient waits, poor patient experience, delayed clinical decision making, increased patient safety risks, increased outsourcing or activity and corresponding loss in productivity / efficiency.		Imminent	12	**L5 x C4 (20)**	⇔	No change to risk score proposed.	**High** ⇔
2.4	Loss of internal efficiency / effectiveness / productivity levels due to staffing constraints or Covid-19 (whether from social distancing requirements, infection control or operational arrangements which in turn impact on supply/demand for services).		Imminent	16	**L5 x C4 (20)**	⇔	No change to risk score proposed.	**High** ⇔
2.5	Potential external impacts from the Surrey Heartlands ICS overall financial, activity level, & waiting list positions as well as requirements for mutual aid.		Imminent	12	**L5 x C4 (20)**	⇔	No change to risk score proposed.	**Moderate** ⇩

3. Digital								
3.1	**Updated description**: There is a risk that the anticipated outcomes to improve quality and safety and to avoid clinical risk, both integral to the Trust strategy, may be compromised if ***the Digital Delivery Programme (which includes the Surrey Safe Care implementation is not stabilised, optimised (embedding, development and exploited) and supported by skilled personnel.***		Med	12	**L3 x C4 (12)**	⇔	Risk description updated but no update to risk score proposed	**High** ⇔
3.2	Critical Systems Maintenance and Replacement: Failure of key IT systems could lead to issues of patient safety, experience or quality risks, or process delays.		Imminent	12	**L3 x C3 (9)**	⇔	No change to risk score proposed.	**High** ⇔
3.3	Known Cyber security and data protection breaches could threaten the provision of IT systems, leading to issues of patient safety, experience or quality risks, or process delays.		Med	12	**L4 x C3 (12)**	⇧	Following the recent extended disruption to the OneAdvanced Adastra solution it is proposed to increase the Consequence and Likelihood.	**Moderate** ⇔

3.3a	Unknown cyber security and data protection breaches could threaten the provision of IT systems, leading to issues of patient safety, experience or quality risks, or process delays.		Med		L3 x C4 (12)	⇔	No change to risk score proposed.	**Moderate** ⇔
4.People								
4.1	Inability to accurately model workforce requirements, may result in failure to align workforce supply, to meet current and future acuity and demand, resulting in a misalignment with both the service requirement and/or the financial plan		Med	9	L4 x C4 (16)	⇔	No change to risk score proposed.	**Low** ⇔
4.2	Unable to staff to current and future demand resulting in a negative staff and patient experience.		Med	9	L4 x C4 (16)	⇔	No change to risk score proposed.	**Low** ⇔
4.3	Individuals and teams do not feel listened to, empowered and valued resulting in a negative impact on staff and patient experience		Long	12	L4 x C4 (16)	⇔	No change to risk score proposed.	**Moderate** ⇔
5.Collaborate								
5.1	Internal strategic risk: There is a risk that the benefits of the Trust strategy are not delivered. This is caused by a lack of capacity and/or oversight and would result in the desired effect and intended benefits of the strategy not being achieved or that sustainability of patient care becomes significantly challenged.		Long	16	L4 x C4 (16)	⇔	No change to risk score proposed.	**High** ⇔
5.2	External strategic risk: There is a risk to delivery of the Trust current strategy. This is caused by ineffective or insufficient focus on stakeholder management or by external factors such as decisions taken by national, ICS, ICP which may not correspond or may adversely impact delivery our objectives or undermine our service sustainability.		Imminent	12	L5 x C4 (20)	⇔	No change to risk score proposed.	**Significant** ⇔

NPSA Scoring Matrix

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	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