SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

2020/21 STRATEGIC BOARD ASSURANCE FRAMEWORK

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
2020 Vision	1	Toby Lewis CEO (updated by F Mahmood, Chief People Officer)	There is a risk that management bandwidth does not match organisational and system wide ambition because of either recruitment or capability difficulties, leading to project delays that compromise our improvement trajectory to meet our undertakings and ambitions. **Initial Risk** — May 2019: **12** (3 x4) **Current Risk** — January 2021: **12** (3 x 4) **Target score**: **8** (2 x 4) **Target date**: Jan 2020 Overall Movement ⟷ Assurance level — ADEQUATE	People and Organisation Development	Vacancy analysis for all 8a and above roles to ensure that the correct management resource is allocated to our work priorities so that we hit our delivery timetable.	Group reviews are embedded with additional capacity and support being provided by the Improvement Team. Progress reporting to POD Reports to Remuneration Committee on appointment of key Deputy Director vacancies.	Requires piece of comparison work to focus on value and sustainability of Band 8 function in clinical and corporate areas	Complete
					A2E PDR process for all senior leaders, independently validated to ensure skills and capability are matched to service requirements is now complete. Alignment of staff/organisation objectives has taken place as part of the moderation process.	Monitored by Workforce Delivery Committee and CLE. Monitored by People and OD Committee and Board.	Need alignment between people's objectives and organisation's objectives	Complete
					Coaching and mentoring programme Monitoring of attendance levels through Learning & Development Committee to ensure staff complete course and analyse reasons for non-completion e.g. sickness, rostering issues. Appointment of a BRM who can interpret data into a set of requirements that will ensure the right staff start and complete the programme.	Monitored by WDC, CLE, POD and Board.		Complete
					IQPR & 2020 Vision reporting to the Board on the performance of key programmes running to time.	Monitored by PMC, CLE, Board committees and Board.		Complete

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			Risk scores/quarterly movement					
			Mapped high level risks (if any)					
2020 Vision	2	Liam Kennedy, COO	Collapse in local care home provision arising from commercial pressures and immigration policy increases SWBH admissions and reduces patterns of discharge creating pressures on acute hospital beds.	Quality and Safety	**Risk Closed**			
2020 Vision	3	Liam Kennedy, COO	There is a risk that difficulties in recruiting and retaining local GPs leads to fragmentation within practice and PCNs and unpredicted patterns of referral behaviour and LTC emergency care, resulting in unmet demand or need because our system is not operating to its 5 year plan.	Board		Proposal to Close Risk to be submitted to next meeting of Quality & Safety Committee as this is now less of an organisation risk than a system risk.		

Risk scores table for SBAF Ref 3:

Initial Risk	Current Risk	Target score	Target date
April 2017	January 2021		
9	9	6	Dec 2020
(3x3)	(3x3)	(2x3)	
Overall Movement			
⟷			
Assurance level		LIMITED	

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
			Risk scores/quarterly movement					
			Mapped high level risks (if any)					
2020 Vision	4	David Carruthers, MD	There is a risk that vulnerable service improvement plans are delayed by a lack of cross organisational cohesion or pace, leading to service failures necessitating either emergency changes to service models or patients not being able to access services within the STP footprint.	Quality and Safety	Identification of vulnerable services locally via triangulation of metrics. Place based and provider collaboration discussion across STP/ICS to identify how services can work together optimally Across Black Country, STP meetings focus on local identification of potentially vulnerable services. Meeting attendance is covered by Deputy MD as part of their role. Also monthly meetings of regional medical directors incorporating ability for one provider to assist another with vulnerable services.	Team/group staffing reports to Group Boards Incident reports to Risk Management Committee. Complaints to Executive Quality Committee Mortality reviews Risk Management Committee Above reports are escalated to Operation Management Committee and CLE. SBAF risk report goes to Quality and Safety Committee. STP considers performance data, group reviews, staffing vacancies, complaints and incidents data. Discussion via CRG of STP and development of shared governance committee with STP partners Meeting outcomes reported to CLE and Trust Board.	No clear definition of vulnerable services - Definition of vulnerable service developed, services identified and groups looking at options. Active engagement with ICS development plans and provider collaboration Assess changes needed post Covid as services re start Inability to influence neighbouring trusts – work across STP system now as part of Covid restoration and bigger focus on areas for combined working both for diagnostics in short term and longer term service provision Enhanced working through provider collaboration	
			Service development plans are in place -local service plans focusing on efficiency, staff development, recruitment and service integration. -STP discussions via STP meetings and MD meetings (see above) which look at innovative ways of running potentially vulnerable services across the footprint.			Efficiency and service integration plans via OMC Staff development and recruitment plans	Complexity of service interactions/inter-relationships. Geography for staff and patients. Define components of a service where integration could start from -Remote v onsite -Technology opportunities e.g. MDT/Video conf for patients.	
					Impact of vulnerable service materialising by active operational risk management system which ensures no patient is left without access to service.	Escalation reports to group boards, Operational Management Committee, Executive Quality Committee and CLE.		

Risk score table:

Initial Risk	Current Risk	Target score	Target date
May 2019	January 2021		
12	12	8	May 2021
(3x4)	(3x4)	(2 x 4)	
Overall Movement			
Assurance level		LIMITED	

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
			Risk scores/quarterly movement					
			Mapped high level risks (if any)					
2020 Vision	5	Kam Dhami, Dir of Gov.	**There is a risk that organisational learning does not improve with "Welearn" sufficiently to address our quality improvement ambitions, resulting in the Trust not sustaining a Good rating after 2020.** Initial Risk (May 2019): 12 (4x3) Current Risk (February 2021): 9 (3x3) Target score: 6 (2x3) Target date: May 2020 (4x3) Overall Movement ⟷ Assurance level: LIMITED	Quality & Safety	Framework for reporting risk, incidents and patient feedback is established and embedded. - Incident reporting system - Complaints - Staff survey - Friends & Family Test - Clinical Audit programme - Speak Up Guardian Local clinical audit reported through EQC for oversight quarterly and included in the newly updated governance scorecard to enable greater visibility to Groups	Substantial assurance process is in place to monitor risk/incidents/patient feedback framework. Quality & Safety Committee + CLE provides assurance to Board on Quality and Safety Plan		Complete
					Quality Improvement Half Days (QIHD) established and embedded. Accreditation process established for QIHD Quality Improvement Plan QI training (QSIR) piloted in August 2020. Total of 30 staff have completed QSIR fundamentals and/or QSIR Virtual	QIHD Accreditation standards adjusted to reflect QI methodology along with having an individual with QI knowledge/expertise on accreditation panels to ensure consistency of approach	Single QI methodology (QSIR) is an essential requirement and remains a gap.	
					"Welearn" launched as a pilot scheme in 2018. Welearn from excellence launched as a qualitative approach to reflect everyday brilliance. Where lessons and outcomes can be shared for wider learning, these have been. The learning pack has been replaced by a more robust governance scorecard, which was developed with Group engagement and provides data that spans a 12-18 month period using recognised tools such as SPC charts rather than RAG rating so that Groups can be more responsive to emerging themes and trends	CQC Inspection Report. National audits.		

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
2020 Vision		Director of System	There is a risk that we will not secure or sustain a Midland Met Final Contractor owing to approval delays, resulting in further confusion about the future model and leading to employee flight and service sustainability difficulties in acute care.	EMPA	**Risk Closed**			
2020 Vision	7	David Baker, Director Strategy & Partnerships	There is a risk that not all partners will sign up to the practicalities of the ICP vision and resist change including personnel change, resulting in a hiatus and loss of trust which could imperil our ability to make changes of importance to the long term care model our communities need.	Board	Proposal to close risk as the ICP/Place Based Boards are formed with all partners attending			

Table inside SBAF Ref 7 cell:

Initial Risk	Current Risk	Target score	Target date
May 2019	January 2021		
12	12	8	March 2020
(3 x 4)	(3 x 4)	(2 x 4)	
Overall Movement			
⟷			
Assurance level		LIMITED	

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement	Responsible Board Committee	Controls	Assurances	Gaps and actions	Completion date for action
2020 Vision	8	Martin Sadler, CIO	There is a risk that the immediate pressures that drove the development of our Digital Plan was and is not sufficiently agile and responsive to end-user needs, resulting in a gap between intention and practice over the next three years.	Digital MPA	**Risk Closed**			

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
Finance	9	Dinah McLannahan, Chief Finance Officer	**There is a risk that our necessary level of cash backed cost reduction and income and expenditure plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects.** Initial Risk (April 2017): **20** (4x5) Current Risk (March 2021): **12** (3x4) Target score: **8** (2x4) Target date: March 2021 Overall Movement: ⟷ Assurance level: LIMITED	Finance and Investment	Joined up cashflow forecasting linked to I&E delivery Block income understood for H1 2122, cost forecast understood, route to near breakeven understood Forecast 2122 CIP delivery understood, work underway to close gap over next 6 weeks with plans Rollover budgets, CIP and affordable wte parameters identified	Monthly cashflow and I&E reporting in place STP risk share agreement in place that will assist with adverse variance from plan if others are ahead of plan FIC Work plan agreed for 2122 LTFM reconciled to 1920 outturn and required journey understood MMUH affordability workstream underway	Need to get 21/22 CIP plan as per LTFM in place Secure 2122 Taper Relief Understand H2 position for 21/22 with ICS Establish reserves for 21/22 route to additional funds if covering costs only Establish reserves for 21/22 route to additional funds if covering costs only Complete baseline for planning aligned to LTFM and including all costs to inform income discussions with the ICS Confirm affordability position for 2223 onwards	31/7/21 30/6/21 30/6/21 30/6/21 Ongoing Complete for 2122 30/9/21
Finance	10		**There is a risk that the mechanism for contracting and payment in the NHS caused by a failure of national bodies to require adoption of capitation based contracting will result in the Trust not achieving its aim to be the best integrated care provider in the NHS by not allowing money to flow freely around our local system.** Initial Risk (May 2019): **20** (5x4) Current Risk (October 2019): **12** (4x4) Target score: **8** (2x4) Target date: March 2020 Movement: ⟷ Assurance level: LIMITED	Finance and Investment	ICP Boards held monthly, Trust attendance Finance sub groups established for Sandwell and West Bham ICS DoFs group – ICP financial framework development Trust Membership of National HFMA Payment Systems and Specialised Commissioning Committee CFO attends STP reset programme board	Reporting to ICP Boards Reporting to ICP Partnership Board System financial H1 plan and H2 forward look reviewed at FIC May 2021	Acute Care collaboration programme board to be established Draft shadow budgets for ICPs expected July 21 Reporting of system finance position to be introduced alongside organisational reporting Determine Sandwell and WB allocation split in relation to SW and WB costs in the Trust and place via finance sub groups Determine ICS wide savings versus ICP wide efficiency opportunities ICS wide financial management framework to be developed	Complete 26/7/21 30/6/21 30/9/21 30/9/21 In progress

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
			Risk scores/quarterly movement					
			Mapped high level risks (if any)					
People	11	Frieza Mahmood, Chief People Officer	**There is a risk that labour supply does not match our demand for high quality staff, because of low training numbers or overseas options for students, and therefore we are unable to sustain key services at satisfactory staffing levels resulting in poorer outcomes, delayed delivery or service closures.** Initial Risk / Current Risk / Target score / Target date April 2017 / January 2021 / / 20 (5x4) / 12 (4x3) / 9 (3x3) / May 2021 Overall Movement ⟷ Assurance level — Adequate	People and Organisational Development	Recruitment trajectories monitored through People Plan PMO – via professional group and via clinical group Student numbers, fill rates of key training posts Number of visas allocated to Trust KPI New roles created – and a plan for more creative new ways of delivering the activity Recruitment fill rates per professional and clinical group Retirement trajectory for key areas Apprentice rate to 2.3% Reduction in agency spend with pay spend directed at substantive pay Retention whole organisation strategy	People and OD Delivery Committee with committee minutes People Plan PMO – comparative data and statistics - training records and statistics Clinical Group Reviews – reports on progress on recruitment trajectories, Dashboards Trust Board – Public and Private – public and private reports, IQPR, risk register, minutes, self-assessment returns, turnover data, Regular audits of safe staffing – daily and monthly Regional and national staffing benchmarking Staff survey feedback and results. WeConnect survey feedback and results Clinical leadership executive analysis Midland Met final business case – modelling –modelled up to 2023 linked to the LTFM Production plan / waiting lists / Retention Strategy and Hard to Fill plans presented to Board and Group Reviews	Sufficient knowledge of internal and external offers, and impact on organisation – Covid-19 pandemic impacted this work however internal analysis and focus groups informed new Retention Strategy and Hard to Fill plans Market analysis of attractiveness of SWB as place to work for different professional groups – changed approach to resourcing to focus on localised recruitment resulted in a 50% reduction in vacancies. Analysis of attractiveness to work at senior operational level (risk of retirement profile) Forward look of what the workforce will look like in 5 years' time / 10 years' time – timetable for forward look impacted by Covid-19 pandemic	Ongoing

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
Education, Learning and Development	12		**There is a risk that we do not create the time for our employees to develop over the next two years, and that we are less able to deliver our community based, public health focused model of care at the same time as opening Midland Met.**	People & Organisational Development	Mandatory training statistics from Employee Staff Record (ESR)	Education Learning and Development CLE Committee, minutes, notes and reports	Return on investment data in training spend and how it contributes to organisational effectiveness Rostering improvements – analysis undertaken and reported to Learning & Development Committee.	Complete

Risk scores/quarterly movement:

	Initial Risk	Current Risk	Target score	Target date
	May 2019	January 2021		
	6	6	4	May 2020
	(2 x 3)	(2 x 3)	(2 x 2)	
Overall Movement				
Assurance level		LIMITED		

Controls:

Mandatory training statistics from Employee Staff Record (ESR)

Completion of annual Performance and Development Review KPI

Analysis of training spend via professional group and clinical group KPI'
Work on the job / coaching on the job
Financial investment in training budget
Simulations increasing Number of apprentices in the workforce totally 2.3%

Effective rostering of training and development in to rosters to release staff
Monitoring study leave and release time to attend development

Assurances:

Education Learning and Development CLE Committee, minutes, notes and reports

Training needs analysis informs release time and knowledge for planning release and training time in an informed way

Funded development time within rostered establishments.

Staff survey results / line manager relationships

Rostering improvement being monitored at People and OD Committee

Attendee lists and knowledge of DNA's DNA's reducing Yearly plan for training activities

Corporate People and OD Group Reviews

Completion of PDR's and moderation

IQPR data mandatory training

CQC inspection data

People and OD Delivery CLE Committee

People and OD Board Committee

Feedback from Freedom to Speak Up Guardians

Gaps and *actions*:

Return on investment data in training spend and how it contributes to organisational effectiveness
Rostering improvements – analysis undertaken and reported to Learning & Development Committee. — Complete

Equality assessment to ensure equality of access to learning and development. Complete, part of the widening participation — Complete

PDR analysis of highly talented individuals. Moderation of pdr at senior level, identifying high scores and then ability to access further developmental opportunities. Pandemic has affected progress. — Ongoing

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
Public Health	13		**There is a risk that we do not deliver improved mental health and wellbeing across our workforce because our interventions are not targeted at those at prospective risk, resulting in absence and teams not being able to deliver to their full potential.** Initial Risk April 2017: **16** (4 x 4) Current Risk January 2021: **12** (3 x 4) Target score: **6** (3 x 2) Target date: May 2020 Overall Movement ⟷ Assurance level: ADEQUATE	Public Health	Sickness statistics are monitored through E-Roster and through Employee Staff Record (ESR) Return to work interviews are undertaken Sickness absence policy Trade Union support and engagement Monthly sickness dashboard on Connect Reporting in People Plan PMO on sickness hot sport areas. People Plan theme outlining reducing sickness absence and improving health and wellbeing of the workforce	People Plan PMO monitors bank fill rates on hot spot area wards, high incident reporting, triangulates data including temporary staff filling Group and executive review of sickness absence every two months at clinical group reviews. Monthly reporting to Trust Board – reports, minutes, IQPR which is group specific, Specific board reports on different aspects of People Plan, including sickness absence and training plans. People and OD Delivery Committee – bi monthly scrutiny. Notes, minutes, action logs National and regional benchmarking Staff survey results and we connect survey results	Hidden mental health related absence within other key ESR data points, e.g. MSK. Complete, implementation of a fast track physiotherapy referral process and tracked outcomes. Fully implemented stress risk assessments that will enable us to be proactive and predictive in high risk areas. Complete	Complete Complete
Quality	14	David Carruthers, MD	**There is a risk that the Trust is unable to reduce amenable mortality to the timescale set out in our plans because we do not identify interventions of sufficient heft to alter outcomes.** Initial Risk April 17: **16** (4x4) Current Risk January 2021: **16** (4 x 4) Target score: **12** (3 x 4) Target date: August 21 Overall Movement ⟷ Assurance level: ADEQUATE	Quality and Safety	Management structure substantially in place to support LfD programme. Learning from deaths programme in place with sub-streams set out below. 1. Mortality reduction plan in Quality Plan relating to Sepsis, VTE, Acute MI, Stroke, #NOF, High risk abdominal surgery and Peri-natal mortality. QI projects identified.	Structure reports to Medical Director and oversees running of LfD programme. Progress monitored by LfD committee and overseen by Quality and Safety Committee. Escalation to Board. Monitored by LfD committee via tracking reports. Escalation reports to Q&S if problems identified.	Natural time lag between interventions and monitoring data being produced. Feedback process to groups being developed. Process for learning needs to be developed and embedded. - *"Welearn" programme developed.*	Complete Complete

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
					2.Data analysis programme focussing on alerts arising from clinical areas and/or conditions. Coding processes improved.	Monitored by Quality and Safety Committee.	Further improvements in coding underway focusing on palliative care data, weekend admissions and site specific. Coding using auto-coding algorithm as well as learning material has led to an increase in depth of coding for acute and planned care admissions. Co-working between clinicians and coding department continues	
					3.External mortality alerts from CQC or CCGs.	Received by LfD committee and overseen by Q&S.	National picture for Learning for Deaths is constantly changing as more evidence becomes available. Responsive to changes in national position particularly re database for recording ME reviews, requirements for MMCD and discussion with families.	
					4. All Medical examiners are now in place. MEs and judgmental reviewers will provide 3 monthly analysis of amenable mortality.	Monitored by LfD and overseen by Q&S. Sepsis CQUIN VTE National Target MINAP data SSNAP data NHFD EmLap data	SJR training in now well attended and reviews being undertaken as request for first tier reviews by clinical colleagues reduces as ME activity increases to fill this work. This feeds into the LfD committee with learning points identified and cases where death could have been potentially avoided discussed.	
					Review of coding process needed	Review of coding practices to improve accuracy of data for HSMR – in progress with Coding attendance at LfD Committee	Coding process identified as an issue in episodes of care with change too frequently so definitive diagnosis not identified. Terminology used in clerking document in Unity not compatible with current coding practice.	
Research and Development	15		There is a risk that we are unable to achieve our qualitative and quantitative goals for research because we do not broaden the specialties that are research active, principally because we are unable to recruit personnel and provide time and infrastructure to deliver commercial, CRN, and personal research, thus limiting research translation from science to practice.	Quality & Safety	Research & Development Plan. Growth of R&D activity managed through group PMO R&D plans. Data showing take up of research projects is fed back to groups driving better participation.	Monitored by Research & Development Committee. All groups are represented with rota of presentations. Escalation reports to Q&S.	We need to increase our numbers of commercial studies in order to generate income – *Plan in place to do this.*	
					R&D Director in place	Reports to Med Director with escalation reports to CLE.	Post currently out to recruitment due to post holder leaving – this will affect assurance process as it will take a period of time to get new post holder up to speed.	

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			Risk scores/quarterly movement								
			Mapped high level risks (if any)								
			Initial Risk	Current Risk	Target score	Target date		Active medical recruitment strategy focusing on new consultants with a research interest. University representative sits on recruitment panel. Recruitment to vacant senior posts actively pursued. Focus on balance of Covid and non-Covid trials leading to a change In recruitment focus.	Monitored by Workforce Development Committee. Change in recruitment focus as most non-Covid trial work suspended	Oncology study recruitment restricted due to change in service. – *Risks reviewed frequently*. Understanding timelines of opening of non-Covid trials.	
			April 2017	October 2019		August 21					
			9	9	6						
			(3 x 3)	(3x3)	(2x3)						
			Overall Movement								
			⟷								
			Assurance level		ADEQUATE						
Digital	16	Martin Sadler CIO	There is a risk that strategic initiatives and the Trust's digital ambitions will not be achieved as a result of the unreliable Informatics infrastructure, the lack of digital/ technical skills, the lack of business owner involvement or customer insight, and inappropriate third party support arrangements which may lead to a lack of faith in Informatics and a lack of timely engagement with them and the inability to achieve the improvement we are seeking.				DMPA	**Risk Closed**			

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
			Risk scores/quarterly movement					
			Mapped high level risks (if any)					
Digital	17	Liam Kennedy, COO	**There is a risk that we do not automate our processes, standardise them safely and reduce errors and duplication because not all our staff develop and retain the necessary skills and confidence to optimise our new electronic patient record (Unity).** Initial Risk (May 2019): **16** (4 x 4) Current Risk (June 2021): **6** (2 x 3) Target score: **8** (2 x 4) Target date: Dec 2020 19/20 Quarterly Movement ⟷ Assurance level: ADEQUATE	Digital	Unity implementation plan comprising of Technical Readiness, People (development) and Go Live and Optimisation. IT Hardware implementation plan tracked against a 14 point infrastructure plan. Weekly tracking of end user training. Digital champion and super user training designed Workforce development plan setting out competencies/KPIs for individual staff to meet. Reporting to start in June. Departmental readiness criteria agreed. Includes future work flow processes. Reporting to start in June. Optimisation KPIs agreed.	Monitored by Unity Executives (CEO, COO, Director of OD, CIO). Overseen by Digital Committee and Digital MPA Committee reports on completeness vs planned delivery / milestones. Team competencies have been identified and are ready to be measured at go live. There is a comprehensive optimisation plan for Unity which ensures that the 6 months post go live covers the essential elements of Trust use of the system Tracking of use data will start at go live and will be fed back to team leaders. Optimised teas will be given priority in requests for enhancements and changes to unity post go live.	Need to identify rewards regime for staff	Complete

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement / Risk scores/quarterly movement / Mapped high level risks (if any)	Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
Estates	18	Toby Lewis, CEO	There is a risk that implementation of changes to commissioning in West Birmingham prevents the Trust and partners from delivering a common approach to integrated care for all patients using Midland Met resulting in operational deficiencies after the opening of the hospital.	Board	Scale of risk identified via the Midland Met full business case.	FBC presented and discussed at Board.	Implementation structure for Midland Met integrated care unclear – *Clarity to be provided by September 19*

Need to develop controls to address operational deficiencies that may occur when new hospital opens.

Need to identify what "good" would look like if separation occurs. | Sept 2019.

April 2020. |

Risk scores table:

Initial Risk	Current Risk	Target score	Target date
April 2017	October 2019		
20	9	6	March 2020
(5 x 4)	(5 x 3)	(2 x 3)	

19/20 Quarterly Movement			
Q1	Q2	Q3	Q4
↓	↓	↔	-
Assurance level		LIMITED	

Controls (continued):

Changes in creation of NHS Long Term plan to replace centralised commissioning. Executive Leads/CEO participation in STP and CCG process.

Introduction of per capita finance model for April 2020/21.

Creation of two care alliances in Sandwell and West Birmingham.

Establishment of "postcode blind" commissioning for key services including community nursing and liaison psychiatry.

Assurances (continued):

Regular reports to Board on changes in commissioning landscape.

Finance report to FIC with concerns escalated to Board.

Progress reports to Board.

Gaps and actions (continued):

Developing key metrics to ensure geographical disparities in the availability of "good" care are eliminated.

Strategic Plan	SBAF Ref	Executive Lead	Strategic Risk Statement				Responsible Board Committee	Controls	Assurances	Gaps and *actions*	Completion date for action
			Risk scores/quarterly movement								
			Mapped high level risks (if any)								
Estates	19	Director of System Transformation	There is a risk that we are unable to sustain services on 2 sites until 2022 without service reconfiguration or investment in non-retained estate. This would compromise our ability to deliver seven day multi professional services because locational alignment is not achieved concurrently.				Estates Major Projects Authority	Workforce triggers risk assessment completed. KPIs tracked monthly. Medical workforce development and recruitment plan over seen by Urgent Care Board. Estates Plans for retained and non-retained estate. 7 day standard governance/compliance oversight report. Reconfiguration of respiratory and paediatrics at City complete. Covid reconfigurations aligned to MMUH model to remain in place. Reconfiguration evaluations via EDC at month 6 post reconfiguration.	Overseen via Urgent Care Board Estates Development Committee Quality & Safety Committee Project board Clinical Leadership Executive	7 day dashboard action has been completed. The information will be use at the Urgent Care Board, 7 day clinical standards assurance and baselining data prior to the Midland Met clinical service move.	Complete
			Initial Risk	Current Risk	Target score	Target date					
			April 2017	October 2019							
			8	12	8	Dec 2019					
			(3x4)	(3x4)	(2x4)						
			Overall Movement								
			⟷								
			Assurance level		ADEQUATE						