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| **Agenda No** | 69-22 |
| **Name of meeting** | Trust Board | | | |
| **Date** | 15.12.2022 | | | |
| **Name of paper** | Board Assurance Framework | | | |
| **Strategic Goal** | All | | | |
| **Author** | Company Secretary | | | |
| There have been some revisions to the BAF since the version that came to Board in September, as set out, including further alignment with the strategic goals and the priorities within the Improvement Journey and metrics in the IQR.  The BAF is received by the Board as one of three primary documents, along with the Integrated Quality Report and Improvement Journey. These documents are also be used by Committee Chairs to help ensure meetings take a risk-based approach to where it should focus. This is reflected in the committee reports to the Board, which reference the related BAF risk.  The BAF was reviewed by the Audit & Risk Committee on 7 December; see its report to the Board (agenda item 67-22).  The BAF risks have also informed the focus of this Board meeting, as set out in the separate cover papers.  The Board is asked to use this report to inform its discussion and, in particular, cross referencing against the stated controls and mitigating actions and, using the assurance cycle referred to in the Chair’s report, where gaps in control are identified, agree what further assurance/corrective action needs to be taken. | | | | |
| Does this paper, or the subject of this paper, require an equality impact analysis (‘EIA’)? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases). | | **No** | | |

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| **Board Assurance Framework**  **Section A: Strategic Direction** |

## Strategic Goals / Corporate Priorities

* 1. This Board Assurance Framework is informed by Trust strategy ‘*Sustainable SECAmb’* and the related strategic goals. These are:
* **Delivering Modern Healthcare for our patients**

*A continued focus on our core services of 999 & 111 Clinical Assessment Service*

* **A Focus on People**

*Everyone is listened to, respected and well supported*

* **Delivering Quality**

*We listen, learn and improve*

* **System Partnership**

*We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care*

* 1. It also aligns with the current priorities within the Improvement Journey. These are:

* **People & Culture** *Improving our culture, engage our people, and support development of our teams*
* **Quality Improvement** *Embedding quality amongst everything we do*
* **Responsive Care** *Improving operational performance and patient care*
* **Sustainability & Partnerships** *Ensuring long-term sustainability*
  1. These priorities are in the process of review in line with the business planning cycle for 2023/24 and will be covered in the Improvement Journey report to Board on 15 December 2022.

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| **Board Assurance Framework**  **Section B: BAF & Risk Overview** |

## Introduction: The BAF

* 1. It is a requirement for all NHS provider Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks.
  2. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all of the relevant information on the risks to the Board being able to deliver the organisation’s objectives.
  3. This BAF sets out the principal risks and how they could impact on the strategic goals. The detail of each risk is set out in Appendix A.
  4. Section C provides context by identifying the vehicles and mechanisms for maintaining oversight of delivery.

## Risk Management

* 1. Despite the improvement made in recent months there is still insufficient assurance that the Trust’s risk management governance is able to fully assure the Board. Rapid corrective work is being undertaken to address this situation, as set out in the Improvement Journey, and the Executive Management Board and Audit & Risk Committee are maintaining oversight of this.
  2. A Board session was held on 1 December to review progress with risk management, specifically in relation to the Warning Notice. This helped to provide further understanding of the process of risk management.

* 1. Section E has been added to outline the Trust’s extreme risks within the corporate risk register. These are risks that are deemed to not explicitly affect the strategic priorities but as they score 15 or above, they are the highest (non-BAF) risks on the risk register.

## Structure of the BAF Risk Report

* 1. This report helps to focus the Executive and Board of Directors on the principal risks to achieving the Trust’s strategic goals and in-year objectives and to seek assurance that adequate controls and actions are in place to manage the risks appropriately.
  2. The Board agenda has been organised against the strategic goals and committee agendas reflect how they align with the specific BAF risks. This is used in the planning for each meeting and confirmed in the related escalation report to the Board.
  3. The BAF is structured and mapped against the four strategic goals (outlined in table 1).

**Table 1: Strategic Goals**

|  |  |  |  |
| --- | --- | --- | --- |
| **Strategic Goal 1** | **Strategic Goal 2** | **Strategic Goal 3** | **Strategic Goal 4** |
| **A Focus on People** | **Delivering Quality** | **Delivering Modern Healthcare for Patients** | **System Partnership** |
| Everyone is listened to, respected and well supported | We Listen, Learn and improve | A continued focus on our core services of 999 & 111 Clinical Assessment Service | We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care |

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| **Board Assurance Framework**  **SECTION C: Oversight & Delivery** |

## Oversight & Delivery

* 1. There are a number of mechanisms for maintaining oversight and delivery of the four strategic goals and these are identified in Table 2. The most significant is the improvement journey which is aligned with the four strategic goals.

**Table 2: Strategic Goals aligned with Improvement, BAU Delivery and Oversight**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strategic Goals | 1. A Focus on People | 2. Delivering Quality | 3. Delivering Modern Healthcare for Patients | 4. System Partnership |
| Everyone is listened to, respected, and well supported | We Listen, Learn and improve | A continued focus on our core services of 999 & 111 Clinical Assessment Service | We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care |
|  |  |  |  |  |
| Improvement Journey  Programme &  Improvement Priorities | **People & Culture** | **Quality Improvement** | **Responsive Care** | **Sustainability & Partnerships** |
| **Text  Description automatically generated** | **A picture containing text  Description automatically generated** | **Logo  Description automatically generated with low confidence** | **Logo  Description automatically generated** |
| **Improving our culture, engage our people, and support development of our teams** | **Embedding quality amongst everything we do** | **Improving operational performance and patient care** | **Ensuring long-term sustainability** |
|  |  |  |  |  |
| Enabling Board Approved Strategies | * People Strategy * Clinical Education * ETD Strategy * Inclusion Strategy * Health & Wellbeing | * Clinical Strategy * End of Life Care * Dementia Strategy * Medicines Optimisation * Patient Experience | * Community Resilience * Fleet Strategy * Estates Strategy | * Green Strategy * Digital Strategy |
|  |  |  |  |  |
| Board Assurance | Executive Managament Board &  Workforce and Wellbeing Committee | Executive Managament Board &  Quality and Patient Safety Committee | Executive Managament Board &  Quality & Patient Safety and  Workforce & Wellbeing Committee | Executive Managament Board &  Finance & Investment Committee  &  Audit Committee |

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| **Board Assurance Framework**  **SECTION D: Risks** |

## BAF Risks

* 1. The Board Assurance Framework has ten strategic risks. Following the review by the committee in September a distinct Culture risk has been added.
  2. Each strategic risk has been reviewed by the lead Executive Director and updated to ensure identified actions are appropriate and have appropriate timeframes.
  3. The Risk and Assurance Group meets weekly and reviews all risks on the risk register and reports to SMG. The separate Risk Management Report is provided to the committee and a version of this is now received by EMB, each month.
  4. In addition, the Audit & Risk Committee has risk management as a standing item.
  5. In this version each risk has included a section cross referencing to the relevant SPC chart from the IQR, where applicable. Appendix Key to the SPC icons is below.
  6. In the actions sections of each risk we have referenced where they relate to a workstream within the Improvement Journey.
  7. Section E includes the non-BAF ‘extreme’ scoring risks.
  8. Risk 257 (Improvement Journey) will be reviewed following the meeting with the CQC on 18 January 2023, when the Board will be presenting the progress made against the Warning Notice. This review will include consideration to how the Improvement Journey becomes the mechanism by which the Trust delivers against its Strategic Goals on a sustainable basis. Noting the current governance was setup to deliver against the regulatory obligations, which will not be an appropriate or sustainable approach going forward in the context of delivering improvement against a strategic framework.

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## **BAF Dashboard**

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| Strategic Goal 1 | Strategic Goal 2 | Strategic Goal 3 | Strategic Goal 4 |
| A Focus on People | **Delivering Quality** | Delivering Modern Healthcare for Patients | **System Partnership** |
| Everyone is listened to, respected and well supported | We Listen, Learn and improve | A continued focus on our core services of 999 & 111 Clinical Assessment Service | We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk ref** | **Thematic Risk Title** | **Oversight Committee** | **Strategic Goal Impacted** | | | | | **Initial risk** | **Current Risk (Current Position)** | | | | | | | | **Change** | **Target score** | **Target date** |
| 1 | 2 | 3 | 4 |  | Sep 21 | Nov  21 | Jan  22 | Mar  22 | May 22 | Aug 22 | Sep 22 | Dec 22 |
| 14 | Operating Model | QPS |  |  |  |  |  | 20 | 20 | 20 | 16 | 16 | 16 | 16 | 20 | 20 |  | 08 | Mar-24 |
| *255* | Workforce – Recruitment | WWC |  |  |  |  |  | 20 |  |  |  |  |  | 16 | 16 | 16 |  | 04 | Mar-23 |
| 13 | Workforce – Retention | WWC |  |  |  |  |  | 16 | 16 | 16 | 12 | 12 | 12 | 16 | 16 | 16 |  | 08 | Mar-24 |
| Tbc | Culture & Leadership | WWC |  |  |  |  |  | 16 |  |  |  |  |  |  |  | 16 | NEW | 08 | Mar-25 |
| 17 | Integration of 111 & EOC | QPS/FIC |  |  |  |  |  | 16 |  |  | 16 | 16 | 16 | 16 | 16 | 16 |  | 08 | Oct-22 |
| *256* | Quality Improvement | QPS |  |  |  |  |  | 16 |  |  |  |  |  | 12 | 12 | 12 |  | 04 | Jun-23 |
| *257* | Improvement Journey | All |  |  |  |  |  | 12 |  |  |  |  |  | 08 | 12 | 12 |  | 04 | Jan-23 |
| 15 | Education Training & Dev | WWC |  |  |  |  |  | 16 | 16 | 12 | 12 | 12 | 12 | 09 | 09 | 09 |  | 06 | Mar-23 |
| 16 | Financial Sustainability | FIC |  |  |  |  |  | 16 | 16 | 16 | 16 | 12 | 12 | 16 | 16 | 16 |  | 08 | Mar-23 |
| 71 | Cyber Attack | FIC |  |  |  |  |  | 16 |  |  |  |  |  |  | 12 | 12 |  | 09 | TBC |

## **BAF** **Risks**

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|  | | **BAF Risk ID** **14**  Operating Model | | | | **Target Date:**  March 2024 | | |
| **Underlying Cause / Source of Risk:**  Our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need, and there is a risk that if we do not address this in a timely way then we will continue to fall short of achieving the standards set out in the Ambulance Response Programme and therefore delivering safe and effective patient care. | | | **Accountable Director** | | Executive Director of Operations | | | |
| **Committee** | | Quality & Patient Safety / Performance | | | |
| **Initial Risk Score** | | **20** (Consequence 4 x Likelihood 5) | | | |
| **Current Risk Score** | | **20** (Consequence 4 x Likelihood 5) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **08** (Consequence 4 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Responsive Care priority within the Improvement Journey focusses on key actions to improve processes / use of resources, such as H&T, JCT (see Improvement Journey Update) * Use of REAP and SMP to help match resource with demand * Integrated Plan agreed with commissioners to increase clinical workforce to 2555 WTE * Performance Cell capability is helping to forecast resource gaps / trajectory against ARP | | | **999-9 “**Hear and Treat” | | | Icon  Description automatically generated | Icon  Description automatically generated |
| **999-11 “**JCT Allocation to Clear at Scene Mean” | | | Icon  Description automatically generated | Shape, circle  Description automatically generated |
| **999-11 “**JCT Allocation to Clear at Hospital Mean” | | | Icon  Description automatically generated | Shape, circle  Description automatically generated |
| **999-2** “Cat 1 Mean” | | | Icon  Description automatically generated | Logo  Description automatically generated |
| **999-4 “**Cat 2 Mean” | | | Icon  Description automatically generated | Logo  Description automatically generated |
| **WF-1** “Number of Staff WTE” | | |  |  |
| **Gaps in Control** | | | | | | | | |
| * Slow progress moving to a more virtual model * Stated actions help to improve the current approach / contribute to future model but we haven’t yet agreed the vision for a new operating model, internally or in collaboration with system partners. | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (-) Operational Performance / ARP standards not being achieved  (+) ARP trajectory for Q1 was met as report to August Performance Committee  (-) low provision of hours  (-) High attrition is undermining the additional clinicians being recruited | | | Greater focus is needed at EMB and Board on the road map for how the operating model will be re-designed. | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **Rota Implementation (RC-1a & b)**: Improve staffing allocations delivered through new rotas by day/hour according to demand/activity, delivering improved staff experience, more efficient utilisation of limited resources, timely responses to the highest-acuity calls, and improved patient outcomes and experience. | Director of Operations | TBC |  |
| **Hear & Treat (RC-3):** Increase the number of incidents where 999 calls are successfully completed without dispatching a physical resource, resulting in improved patient outcomes and experience, and improved staff experience, i.e., dispatching staff to the most appropriate calls. | Director of Operations | 03/11/2023 |  |
| **Dispatch Review (RC-4):** Improve the efficiency and effectiveness of dispatch function, contributing to greater patient outcomes, experience and ARP performance across all categories. | Director of Operations | 24/04/2023 |  |
| **Job Cycle Time (RC-2)**: Improved overall ambulance availability through a reduction in job cycle time providing timely responses to the highest-acuity calls, improved patient outcomes and experience, and improved staff experience. | Director of Operations | 30/12/2022 |  |
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|  | | **BAF Risk ID** 255  Workforce - Recruitment | | | | | **Target Date:**  **March 2023** | | |
| **Underlying Cause / Source of Risk:**  Risk that we do not achieve the recruitment plan to increase our frontline workforce to 2555 WTE, as set out in the 2022/23 Integrated Plan. This will result in consistently being unable to provide the target operational hours and therefore will impact adversely on patient care and staff wellbeing. The risk also exists within our call centres due to the re-opening of Gatwick Airport post-pandemic and the move to Medway impacting colleagues moving from Coxheath to the new Medway site in 2023. EMA call-handler recruitment significantly increased due to high attrition and the 2022/23 plan targets. | | | **Accountable Director** | | Executive Director of HR | | | |
| **Committee** | | WWC / Performance | | | |
| **Initial Risk Score** | | **20** (Consequence 4 x Likelihood 5) | | | |
| **Current Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **04** (Consequence 4 x Likelihood 1) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | **Integrated Quality Report Metrics for Assurance** | | | | | **Variation** | **Assurance** |
| * Integrated Workforce Plan monthly monitoring of projected position * Additional Recruitment Events * International Recruitment * Increasing capacity of compliance checks driving delays in EMA recruitment | | **WF-1** “Number of Staff WTE” | | | | |  |  |
| **WF-3** “Time to hire” | | | | |  |  |
| **999-12** “999 Frontline Hours Provided %” | | | | |  |  |
|  | | | | |  |  |
|  | | | | |  |  |
| **Gaps in Control** | | | | | | | | | |
| The Trust is currently 128 WTE behind on its frontline workforce plan for the month of October. The projected shortfall by the end of the year is projected to be 33 WTE against the plan of 2555 WTE due to the mitigating actions taken through AAP recruitment. Our EMA establishment is currently 51 WTE behind plan, with a projected shortfall of between 49 and 72 WTE against an requirement of 277 WTE by end of the FY. | | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | | | **Gaps in assurance** | | | | |
| (-) October Integrated Plan: 128 WTE below plan (999 frontline)  (-) October Integrated Plan: 51 WTE below plan (EOC EMA)  (-) On road hours significantly below target  (-) Higher than normal turnover in EOC and 111  (+) Time to Hire has seen a reduction with special cause variation  (+) Projected WTE position for end of FY is mitigated for 999 frontline  (-) Impact on call handling performance due to projected 49 to 72 WTE shortfall against 277 WTE end of FY plan | | | | |  | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **(P&C-7)** To compensate against the additional attrition and known gaps in the recruitment pipeline there has been additional recruitment events held to recruit external AAPs. | Director of HR | 31.03.2023 | To date there have been 85 successful candidates offered a position (Includes already started, 54 yet to start on a course and 13 have a TBC date) |
| **(P&C-7)** International paramedic recruitment - these candidates have a longer turnaround time from offer to start and any offers made going forwards will not likely start within this financial year. | Director of HR | 31.03.2023 | Offered to ~~3~~4 candidates so far (five started), with aim to offer 75 by 31.03.2023. |
| Proposal to utilise NQPs within the EOC if they have not yet obtained a C1 licence. This will enable the Trust to retain these staff and reduces the risk of candidates accepting offers at neighbouring services who accept NQPs without a C1 licence. This will also bolster the 999 clinical workforce teams’ capacity over the winter period and increase hear and treat rates. | Director of Operations  Medical Director | tbc |  |
| In terms of recruitment process for EMA, a significant capacity gap has been identified which is severely affecting the compliance checking process due to significantly more EMAs in the recruitment pipeline than normal.  We currently are recruiting more than four times the normal of staff in this area. This has been escalated to the CFO to ensure funding can be made available to fund additional temporary capacity in the compliance check team, which will clear the current outstanding cases by April 2023. | Director of HR | Tbc |  |
| **(P&C-7)** Recruitment Pathway examined to identify where efficiencies can be made | Director of HR | 31.03.2023 | Work has started to look into whether it is feasible to verbally offer a candidate at the end of the assessment day. It’s recognised that there will be extra resource needed for this from recruitment to check that all the assessment paperwork is correct and the candidate has passed along with considerations prior to offer. This will significantly reduce the time taken to offer and have a positive impact on the overall time to hire. A pilot is to be discussed and agreed. Associate Director of Operations supporting this proposal.  If this isn’t a viable option the workloads of the recruitment team will be reviewed and resource moved to help accommodate assessment day administration, so that no delays are related to the subsequent increase of processing for one individual. This review and new process will be implemented by 01/10/22.  Pre-employment check time taken to be added to the recruitment pipeline dashboard with a target date of 01/10/22. Power Bi to show this information.  The review is in progress and is part of the ongoing work which utilises Lean 6 Sigma defining stable processes as part of the programme. This will utilise the fusion of the two disciplines – Lean which seeks to improve flow in the value stream and eliminate waste and Six Sigma which uses a powerful framework and statistical tools to uncover root causes to understand and reduce variation resulting in a defect free process. Each stage of the review will look at chunks of the process, and with careful work will define, measure, analyse, improve and then control the new processes. Without these key steps in place the recruitment team will continue to work with waste undetected. This process also needs data to enable the reflection and analysis to ensure that any adjustments made to processes are effective, and sustainable.   * Stage 1 to map current processes – target completion 01/10/22. * Stage 2 to build effective measure of data – target 01/11/22. * Stage 3 to analyse data and identify ineffective processes – target 01/12/22. * Stage 4 Improve processes – target 01/01/22. * Stage 5 Control processes and monitor for sustained improvements – target 31/03/23   The KPIs identified in the recruitment pipeline dashboard will show our progress and reduction in TTH. Target date to remain at 31/03/23 for completion. |
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|  | | **BAF Risk ID** **13**  Workforce Retention | | | | **Target Date:**  **March 2024** | | |
| **Underlying Cause / Source of Risk:**  Risk of higher than planned turnover and loss of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce. | | | **Accountable Director** | | Executive Director of HR | | | |
| **Committee** | | WWC / Performance | | | |
| **Initial Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Current Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **08** (Consequence 4 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Work in partnership with six higher education institutions (HEIs) for pre-registration paramedic education programmes * Clinical Education Strategy & Delivery Plan * Workforce Plan agreed as part of the Integrated Plan * Raised at system assurance meeting and ICB Chief People Officer Meeting. * Retention Plan agreed / reviewed by WWC | | | **WF-1** “Number of Staff WTE” | | |  |  |
| **WF-48** “Annual Rolling Turnover Rate %” | | | A close-up of a logo  Description automatically generated with low confidence |  |
| **WF-49** “Sickness Absence %” | | | Icon  Description automatically generated |  |
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|  | | |  |  |
| **Gaps in Control** | | | | | | | | |
| * The Trust has not agreed its strategic approach to clinical portfolios * There is no ICS/System workforce plan | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (-) Shortfall of paramedics / High attrition  (-) Additional Roles Reimbursement Scheme could lead to a potential increased attrition of paramedics  (-) Retention issues within paramedics/EOC/111  (+) increase in direct entry students converted to employees | | | Need greater visibility of the effective implementation of the retention plan | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **(P&C-7)** Role specific Staff Survey/Exit Interview action plan for Paramedics and Urgent Care | Director of HR | 31.12.2022 | Retention Plan agreed |
| **(P&C-7)** Development opportunities for Paramedics to progress to Paramedic Practitioners and Critical Care Paramedics. As a minimum we recruit to our budgeted FTE for Paramedic Practitioners and Critical Care Paramedics | Director of HR | 30.03.2024 | Retention Plan agreed |
| **(P&C-8)** Development of a People Strategy and related plans | Director of HR | TBC |  |
| **(P&C-5)** Delivery of the NHS Culture and Leadership Programme | Director of HR | TBC |  |
| Implement the Just and Restorative Culture methodology and principles | Director of HR | TBC |  |
|  | | | |

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| **NEW** | | **BAF Risk ID** **TBC**  Culture & Leadership | | | | **Target Date:**  **March 2025** | | |
| **Underlying Cause / Source of Risk:**  Culture of bullying, sexual misconduct and poor/underdeveloped management and leadership practice resulting in poor employee experience, a high number of employee relations and FTSU cases as well as affecting staff turnover negatively. Culture is insufficiently open and transparent and this leads to insufficient focus on staff concerns which can impact upon patient and staff safety. | | | **Accountable Director** | | Executive Director of HR | | | |
| **Committee** | | WWC | | | |
| **Initial Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Current Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **08** (Consequence 4 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Commenced NHS Culture and Leadership Programme including appointment of a new Programme Director (Cultural Transformation) * Implementing Just and Restorative Culture methodology * Implementing programme of early resolution/mediation training for managers, unions and HR * Trust Board development programme proposal to be presented at Dec 22 Trust Board * Programmes of management development to improve management practice (under collective brand of Made@SECAmb) * Increase in resourcing for FTSU service | | | **WF-44** “Grievance mean case length days” | | |  |  |
| **WF-41** “Count of Until it Stops (Sexual Safety) Cases” | | |  |  |
|  | | |  |  |
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| **Gaps in Control** | | | | | | | | |
| * Insufficient data reporting with clear plans to address leading to lower visibility * Insufficient resourcing in culture improvement work * People strategy not developed yet | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (+) protected time to attend key skills and management development  (+) Employee relations data reviewed regularly at SMG and by HRBPs  (+) regular reporting of ER and FTSU cases to commence to Leadership Team, WWC and Trust Board to improve visibility and monitor progress/highlight areas of concern  (-) WRES, staff surveys, quarterly national pulse surveys  (-) Exit interview data  (+) Statutory and mandatory/keys skills training  (+) Appraisal rates | | | Prioritisation of other issues cf. culture at Board and WWC  Currently FTSU data is not currently reported routinely to senior/top leadership meetings | | | | | |

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| --- | --- | --- | --- |
| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **(P&C-7)** Role specific Staff Survey/Exit Interview action plan for Paramedics and Urgent Care | Director of HR | 31.12.2022 | Retention Plan to be reviewed at EMB SMG on 21.09.2022 |
| **(P&C-7)** Development opportunities for Paramedics to progress to Paramedic Practitioners and Critical Care Paramedics. As a minimum we recruit to our budgeted FTE for Paramedic Practitioners and Critical Care Paramedics | Director of HR | 30.03.2024 | Retention Plan to be reviewed at EMB SMG on 21.09.2022 |
| **(P&C-8)** Development of a People Strategy and related plans | Director of HR | TBC |  |
| **(P&C-5)** Delivery of the NHS Culture and Leadership Programme | Director of HR | TBC |  |
| Implement the Just and Restorative Culture methodology and principles | Director of HR | TBC |  |
|  | | | |

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|  | | **BAF Risk ID 17**  Integration of 111 & EOC | | | | **Target Date:**  **October 2022** | | |
| **Underlying Cause / Source of Risk:**  There is a risk that the plan for the 111 and EOC operational models will be affected as a result of Single Virtual Contact Centre plans which are in progress following a mandate from NHS England. This may lead to negative impacts on performance, patient safety, provider agency and strategic direction. | | | **Accountable Director** | | Executive Director of Operations | | | |
| **Committee** | | Performance Committee | | | |
| **Initial Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Current Risk Score** | | **16** (Consequence 4 x Likelihood 4) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **08** (Consequence 4 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Continue to engage with NHSE directly to seek responses and answers to the concerns and issues raised to date. The NHSE Integrated Urgent Care (IUC) central team has devolved responsibility for the implementation and communication of SVCC to the NHSE regional leads. As such, KMS 111 Head of Service has been in regular contact with the regional NHS E team (and national NHS E IUC Leads, when necessary, i.e., for telephony, commissioning, clinical and medical). * We have full attendance at the three original NHSE national SVCC engagement sessions, in addition to all local NHSE SVCC meetings covering the three workstreams. * Raised concerns via the AACE national forums. * The Associate Director for IT has escalated his concerns and issues through to the national team. Internally, the Associate Directors for IT and for Integrated Care continue to work closely to ensure that SECAmb is fully compliant with the expectations of NHSE regarding the IT and subsequent operational implementation of SVCC. * Implementation has been deferred to at least October 2022 – this is subject to funding that is yet to be agreed. | | | **111-2** “111 Calls Answered in 60 Seconds %” | | |  |  |
| **999-1** “999 Call Answer Mean” | | |  |  |
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| **Gaps in Control** | | | | | | | | |
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| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (-) The first region to go live (London) – had to be subsequently switched off due to IT failures. | | | Regional QIA | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| Work with commissioners to close the funding gap | Director of Finance | Ongoing |  |
| Re modelling the interface between 111 and EOC in terms of call handling and CAS | Director of Operations | TBC | TBC |
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|  | | **BAF Risk ID 256**  Quality Improvement | | | | **Target Date:**  **June 2023** | | |
| **Underlying Cause / Source of Risk:**  The lack of an organisational management systems approach to establishing Quality Improvement as a founding principle will lead to the inability to execute sustainable improvement throughout the organisation that is systematic, prioritised, coordinated, effective, and aligned through from policy to practice to resources available. This will have an adverse impact on patient care, staff well-being, resource sustainability and sustained improvement via the Improvement Journey. | | | | **Accountable Director** | Executive Director of Quality and Nursing | | | |
| **Committee** | Quality & Patient Safety | | | |
| **Initial Risk Score** | **16** (Consequence 4 x Likelihood 4) | | | |
| **Current Risk Score** | **12** (Consequence 4 x Likelihood 3) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | **Treat** | | | |
| **Target Risk Score** | **04** (Consequence 4 x Likelihood 1) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | **Integrated Quality Report Metrics for Assurance** | | | | **Variation** | **Assurance** |
| * The overall requirement and QI (organic) approach agreed * Deputy Director of QI appointed (due to start in Q3) * Improvement journey and workstreams in place that are articulating top-level immediate risks that need addressing – monitored through the IJ structure * Governance groups being refreshed and strengthened to ensure information flow is clear, consistent and comprehensive to address immediate interface between patient care, staff and resources. * QMS/QI presented to some key stakeholders to inform immediate changes to provide good information two-way flows through Quality and Operational groups | | TBC | | | |  |  |
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| **Gaps in Control** | | | | | | | | |
| No Quality Improvement Methodology In place | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | | **Gaps in assurance** | | | | |
| (+) Post-holder in place | | | |  | | | | |

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| **Mitigating actions planned / underway** | | **Executive Lead** | **Due Date** | **Progress** |
| **(QI-8)** QI Strategy, Vision, Aims and Objectives to be developed | Director of Quality | April 2023 | Approach to be agreed at the Board development session on 15 December |
| **(QI-8)** Training plan to be established and underway | Director of Quality | April 2023 |  |
| **(QI-8)** Coordinated learning infrastructure/framework in place – see QI workstreams within the Improvement Journey | Director of Quality | April 2023 |  |
| Board QI session | Director of Quality | 15.12.2023 | Scheduled |
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|  | | **BAF Risk ID 257**  Improvement Journey | | | | **Target Date:**  **January 2023** | | |
| **Underlying Cause / Source of Risk:**  Risk that the Trust is not able to demonstrate significant improvement against the areas highlighted by CQC in the Warning Notice and Must Dos, which could lead to further reputational damage and/or regulatory action. | | | **Accountable Director** | | Executive Director of Planning & Business Development | | | |
| **Committee** | | Trust Board | | | |
| **Initial Risk Score** | | **12** (Consequence 4 x Likelihood 3) | | | |
| **Current Risk Score** | | **12** (Consequence 4 x Likelihood 3) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **04** (Consequence 4 x Likelihood 1) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Improvement Plan is on place – re-prioritised to ensure focus on the Warning Notice and Must Dos. * Monthly Board meetings established to assure delivery of the Plan. * A programme of IJ deep dives at each committee * External support accepted – HR Review; Finance Review; SI / Harm Review. * Quality Summit held * Application for NHSE/I funding and internal business case approved / recruitment made * Improvement Journey Steering Group now chaired weekly by Director of Planning and Business Development. * The programmes have been re-baselined and following a freeze on the 9th September there’s a clear plan and focus on collating of evidence. * Additional support is being drafted to help address the gap in communications / engagement with the programme. * People and Culture Programme has been put under additional support under the internal “intensive support”, this includes creating capacity within DDHR to lead on the programme and allocation of a dedicated PM * A targeted register of evidence has been produced to support focus on outcomes by the expiry of the S29A (Warning Notices) * 3 peer-review sessions have taken place in November, an internal session with colleagues who have not been close to the programme, an external with system partners, and a full Board Development Day, reviewing the progress made against the WN. Peer-review mechanism will be embedded, with external partners. * Current governance structure will continue until the 31st of March following expiry of the Warning * Re-structured Board Agenda aligned to Trust Priorities and Improvement Journey Notices, with a focus on Must Do, Should Do and RSP deliverables. * Committee Deep Dives | | | N/A | | |  |  |
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| **Gaps in Control** | | | | | | | | |
| * Resourcing gaps and capacity constraints identified across the IJ programmes, in particular with delivery leads, not yet closed. Agency project managers have not been retained beyond December due to not meeting the skills required by the programme. * As the programme transitions from Warning Notice focussed to Must Do, Should Do and RSP, there’s some 50 different deliverables that are being mapped out by the programme leads. The Board must seek assurance on how it will maintain oversight of these during this next phase as well as supporting an eventual transition to a Strategically led Improvement Journey. * Sustainability of the current governance arrangements for oversight. | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (+) Report to Board in December  (+) Board Development Day on 1st December  (+) Deep dive sessions completed at committees | | |  | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **(IJ Portfolio)** Mock Inspection | Director of Quality | Sept/Oct | A schedule of mock CQC inspections will carry on following a pre-defined scheduled, covering Polegate and Hastings on the 28th of September, Banstead, and Gatwick, on the 12 and 13th of October. A mock inspection was only conducted at Gatwick due to short notice cancellation from some key partners. Feedback from the Gatwick visit has been shared with the OUM. Polegate and Hastings will be conducted in Jan 2023 and Banstead in Feb 2023. There will be a programme of quality surveillance visits developed with the Sussex ICB Quality team from April 2023. |
| **(QI-1)** Improved reporting to Board to show impact of the actions on our people and patients | Director of Planning | Ongoing | Updated report scheduled for Board 25.08.2022.  Updated IQR in line with Make Data Count Board Development.  Updated reports to Board in September based on deliverables. |
| Preparation for expiry of the S29A Warning Notices | Director of Planning / Director of Quality | 15.10.2022 | Preparation for CQC re-inspection, inclusive of focus sessions on the evidence produced to address each WN shared with entire leadership team. Self-assessment to be conducted by all Board and Senior Managers through October. Board Development and Peer review completed through November against the Warning Notices. |
| Board Well Led Self-Assessment | Chairman / Company Secretary | January 2023 | A well led self-assessment is underway with a Board workshop to be held in January date tbc, facilitated by the NHSE Improvement Director. |
| Board Reporting Framework to be updated to provide assurance against Must-Do, Should-Do and RSP actions | Director of Quality / Director of Planning | February 2023 | Improvement Journey Programme Leads workshop held on 5.12.2022 to review and align progress of each deliverable package against the relevant group.  Weekly Steering Group oversight to be retained. |
| Development of the sustainable models of continuous improvement to support the transition from a compliance driven improvement plan to a strategic driven improvement plan | Director of Quality / Director of Planning | 31.03.2023 | Programme leads for the current delivery groups, current Improvement Journey leads and Deputy Director of Quality Improvement are developing an initial draft of a business case for 23/24. The focus will be in having a structure that enables and supports improvement to happen locally, whilst retaining central visibility for assurance on progress against strategic goals. |
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|  | | **BAF Risk ID 15**  Education Training & Development | | | | **Target Date:**  **March 2023** | | |
| **Underlying Cause / Source of Risk:**  Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development. | | | **Accountable Director** | | Executive Director of Operations | | | |
| **Committee** | | WWC / Performance | | | |
| **Initial Risk Score** | | **15** (Consequence 3 x Likelihood 5) | | | |
| **Current Risk Score** | | **09** (Consequence 3 x Likelihood 3) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **06** (Consequence 3 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Report Metrics for Assurance** | | | **Variation** | **Assurance** |
| * Key Skills delivery programme * Management development programme started in July 2022 * Clinical Education Strategy * Workforce / Integrated Planning & Training gap analysis * Training Plan 2022/23 * Monthly core skills (stat/man) training compliance reporting on Power BI * Agreed increased abstraction levels from 29% to 33% for 2022/23 * Adopted no cancellation approach to key skills | | | **WF-6** “Statutory & Mandatory Training Rolling Year %” | | |  |  |
| **WF-40** “Appraisals Rolling Year %” | | |  |  |
| **999-12** “999 Operational Abstraction Rate %” | | |  |  |
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| **Gaps in Control** | | | | | | | | |
| * Education, Training and Development (ETD) Strategy | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (-) Additional abstraction (carry over of leave due to the pandemic)  (+) Some Key Skills Prioritised in Q1 2021/22 and delivery to staff not had training in past 18 months.  (+) Training has continued despite operational pressures  (+) Board commitment to ETD | | |  | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| **(P&C-6)** Annual training plan 2022/23 | Director of HR | 31.03.2023 |  |
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|  | | **BAF Risk ID 16**  Financial Sustainability | | | | **Target Date:**  **March 2023** | | |
| **Underlying Cause / Source of Risk:**  The Trust is unable to plan to deliver safe quality and effective services in the medium or long-term due to uncertainty over future funding arrangements in both 999 and 111. | | | **Accountable Director** | | Chief Finance Officer | | | |
| **Committee** | | Finance & Investment | | | |
| **Initial Risk Score** | | **20** (Consequence 5 x Likelihood 4) | | | |
| **Current Risk Score** | | **20** (Consequence 5 x Likelihood 4) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | **10** (Consequence 5 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | | **Integrated Quality Reports Metrics for Assurance** | | | **Variation** | **Assurance** |
| * For 22/23, the Trust has mitigated an original planning gap of c.£40m with non-recurrent funding from national allocations. * Funding for the 2022/23 Integrated Plan for 2555 WTE, which improves ARP but does not achieve the standards. * The Trust has reviewed the likely financial outcome for 2022/23 and without remedial action the Trust would have an £8m deficit. The remedial action plans are underway with each directorate to deliver recurrent savings in year to significantly reduce the likely deficit to circa £2m | | | **WF-1** “Number of Staff WTE” | | |  |  |
| **F-9** ”Income (£000s) YTD” | | | NA | NA |
| **F-10** “Operating Expenditure (£000s) YTD” | | | NA | NA |
| **F-6** “Surplus/Deficit (£000s) Month | | | NA | NA |
|  | | |  |  |
| **Gaps in Control** | | | | | | | | |
| * The stated controls are in year measures and unlikely to improve long term sustainability * The ICS systems in Sussex and Kent have communicated to the Lead Ambulance Commissioner (Surrey ICS) that they will not commit to further funding for 23/24 without understanding the demand and capacity issues.  Without rectification and agreement from the systems as to how to manage demand is required. The gap will likely increase if supply side measures (increasing WTE) is the primary solution. * We have commenced the 2023/24 planning round and are intending to achieve 80% of financial & operational planning by the end of December 2022. | | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | | **Gaps in assurance** | | | | | |
| (+) financial management: achieving plan  (-) underlying funding gap / deficit  (-) Cost Improvement Plan | | | We don’t currently have a plan for addressing long term sustainability. The plan is under development, and we will report to the Board early in the New Year. | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| Financial diagnostic by NHS Improvement Director underway looking at internal and external issues. | Chief Finance Officer | September | The report has been shared with the Board. |
| Discussion with commissioners about how to ensure longer term planning | Chief Finance Officer | Ongoing |  |
| Sustainability & Partnerships Programme within the Improvement Journey established | Chief Finance Officer | Ongoing | Programme now in operation and delivering in line with the S&P plan. |
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|  | **BAF Risk ID** **71**  Cyber Attack/Data Security | | | | | **Target Date:**  TBC | |
| **Underlying Cause / Source of Risk:**  There is a risk that the Trust will not be able to prevent cyberattacks given the increasing number and complexity of recent attacks including attacks on key vendors (supply-chain attacks) used by the Trust. | | **Accountable Director** | | Chief Finance Officer | | | |
| **Committee** | | Finance & Investment Committee | | | |
| **Initial Risk Score** | | 16 (Consequence 4 x Likelihood 4) | | | |
| **Current Risk Score** | | 12 (Consequence 4 x Likelihood 3) | | | |
| **Risk Treatment**  **(tolerate, treat, transfer, terminate)** | | **Treat** | | | |
| **Target Risk Score** | | 08 (Consequence 4 x Likelihood 2) | | | |
| **Controls in place (what are we doing currently to manage the risk)** | | | **Integrated Quality Report Metrics for Assurance** | | **Variation** | | **Assurance** |
| * Firewalls are in place to protect the Trust's network perimeter and control inbound / outbound traffic flow * Permissions are based on least-privilege with staff only being given access to what they need as a minimum. Any request for increased permissions are logged and approved via Marval * Anti-virus / Anti-malware is installed on server and laptop / desktop hardware and regularly automatically updated * Servers and laptops / desktops are patched regularly * The Trust and our CAD vendor are alerted to specific risks by NHS Digital to enable us to take swift resolution. * In and out of hours, the Trust is able to now respond to cybersecurity alerts concerning specific devices and works to immediately disable impacted devices and accounts. | | | N/A | |  | |  |
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| **Gaps in Control** | | | | | | | |
| Some servers cannot be immediately patched due to operational impact. They are therefore scheduled for the earliest opportunity.  A standardised action card does not exist to explain how the initial response to a cybersecurity event involving a single user or device should be handled. This is being developed.  A standardised action card does not exist to explain the initial handling of a Trust wide cybersecurity event.  There is no security on-call team with the fall-back being to a mix of the skillsets that are on-call. | | | | | | | |
| **Sources of Assurance: Positive (+) or Negative (-)** | | **Gaps in assurance** | | | | | |
| Controls enable prevention rather than cure. This is always better in cybersecurity as once an attack has occurred it is too late. | | There needs to be an improvement around actions to take post attack to ensure we have appropriate control measures in place to minimise reputational damage, data loss and operational impact. | | | | | |

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| **Mitigating actions planned / underway** | **Executive Lead** | **Due Date** | **Progress** |
| Privilege access management (PAM) implementation, starting with suppliers, then internally | Director of Finance | TBC | Most suppliers are now working with the system and adjustments are being worked through with them to ensure it is fully meeting their needs before moving to internal staff. |
| An action card is being developed to cover single device or user cybersecurity incidents | Director of Finance | 25.11.2022 |  |
| An action card is being developed to cover Trust wide cybersecurity events. | Director of Finance | 25.11.2022 |  |
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| **Board Assurance Framework**  **SECTION E: Non-BAF Extreme Risks** |

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| **ID** | **Title / *Description*** | **Initial Risk Grading** | **Current Risk Grading** | **Target Risk Grading** | **Risk owner** |
| 28 | **Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)**  *There is a risk that people seeking to obtain high risk and/or addictive medications are being enabled as a result of no mechanisms to identify this drug seeking behaviour which may lead to significant patient safety risk and Trust liability.* | 15 | 15 | 06 | Chief Pharmacist |
| 29 | **EPRR Incident Response**  *There is a risk that the Trust’s response to an incident of an EPRR nature will fall short of the requirements outlined in the Major Incident Plan and NHS EPRR Framework.*  *These incidents include but are not limited to: significant or major incidents, transport accidents, multi-site incidents or business continuity incidents.* | 20 | 16 | 06 | Head of EPRR |
| 136 | **Process of tagging medicines pouches is not working effectively**  *There is a risk medicines will not be available for the patient if paramedics are incorrectly completing paperwork following their daily assurance checks. Incomplete or incorrect paperwork leads to pouch tagging errors and there is a risk that the medicine will not be in the right place at the right time for the next Paramedic and patient due to incorrect tagging.* | 15 | 15 | 03 | Chief Pharmacist |
| 16 | **Climate Change**  *As a result of greenhouse emissions, global warming will increase the temperature of the earth over the coming decades. Amongst many impacts this will lead to, climate change is likely to become the biggest healthcare emergency of the 21st Century. This will impact our operating model both on the types of conditions we attend to (i.e. extreme weather), as well as our infrastructure and how we deliver care (i.e. changing our fuels and consumables to meet mandated carbon-reduction targets).* | 15 | 15 | 10 | Director of Planning |
| 273 | **Industrial Action**  *Trade unions are balloting nationally in response the pay award for 2022/23 – in the event of strike action or industrial action short of strikes this could significantly disrupt service provision.* | 16 | 16 | 08 | Director of HR |

## Appendix 1 - Risk Scoring

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|  |  | **Likelihood** | | | | |
|  |  | **1**  **Rare** | **2**  **Unlikely** | **3**  **Possible** | **4**  **Likely** | **5**  **Almost certain** |
| **Impact** |  |
| **Catastrophic**  **5** |  | **5** | **10** | **15** | **20** | **25** |
| **Major**  **4** |  | **4** | **8** | **12** | **16** | **20** |
| **Moderate**  **3** |  | **3** | **6** | **9** | **12** | **15** |
| **Minor**  **2** |  | **2** | **4** | **6** | **8** | **10** |
| **Negligible**  **1** |  | **1** | **2** | **3** | **4** | **5** |

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| **Low** | **Moderate** | **High** | **Extreme** |

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| Table of Consequences | | | | | |
| Domain: | Consequence Score and Descriptor | | | | |
| 1 | 2 | 3 | 4 | 5 |
| Negligible | Minor | Moderate | Major | Catastrophic |
| Injury or harm Physical or Psychological | Minimal injury requiring no / minimal intervention or treatment  No Time off work required | Minor injury or illness requiring intervention  Requiring time off work < 4 days  Increase in length of care by 1-3 | Moderate injury requiring intervention  Requiring time off work of 4-14 days  Increase in length of care by 4-14 days  RIDDOR / agency reportable incident | Major injury leading to long-term incapacity/disability  Requiring time off work for >14 days | Incident leading to fatality  Multiple permanent injuries or irreversible health effects |
| Quality of Patient Experience / Outcome | Unsatisfactory patient experience not directly related to the delivery of clinical care | Readily resolvable unsatisfactory patient experience directly related to clinical care. | Mismanagement of patient care with short term affects <7 days | Mismanagement of care with long term affects >7 days | Totally unsatisfactory patient outcome or experience including never events. |
| Statutory | Coroners verdict of natural causes, accidental death or open  No or minimal impact of statutory guidance | Coroners verdict of misadventure  Breech of statutory legislation | Police investigation  Prosecution resulting in fine >£50K  Issue of statutory notice | Coroners verdict of neglect/system neglect  Prosecution resulting in a fine >£500K | Coroners verdict of unlawful killing  Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter) |
| Business / Finance & Service Continuity | Minor loss of non-critical service  Financial loss of <£10K | Service loss in a number of non-critical areas <6 hours  Financial loss £10-50K | Service loss of any critical area  Service loss of non- critical areas >6 hours  Financial loss £50-500K | Extended loss of essential service in more than one critical area  Financial loss of £500k to £1m | Loss of multiple essential services in critical areas  Financial loss of >£1m |
| Potential for patient complaint or Litigation / Claim | Unlikely to cause complaint, litigation or claim | Complaint possible  Litigation unlikely  Claim(s) <£10k | Complaint expected  Litigation possible but not certain  Claim(s) £10-100k | Multiple complaints / Ombudsmen inquiry  Litigation expected  Claim(s) £100-£1m | High profile complaint(s) with national interest  Multiple claims or high value single claim .£1m |
| Staffing and Competence | Short-term low staffing level that temporarily reduces patient care/service quality <1day  Concerns about skill mix / competency | On-going low staffing level that reduces patient care/service quality  Minor error(s) due to levels of competency (individual or team) | On-going problems with levels of staffing that result in late delivery of key objective/service  Moderate error(s) due to levels of competency (individual or team) | Uncertain delivery of key objectives / service due to lack of staff  Major error(s) due to levels of competency (individual or team) | Non-delivery of key objectives / service due to lack/loss of staff  Critical error(s) due to levels of competency (individual or team) |
| Reputation or Adverse publicity | Rumours/loss of moral within the Trust  Local media 1 day e.g. inside pages or limited report | Local media <7 days’ coverage e.g. front page, headline  Regulator concern | National Media <3 days’ coverage  Regulator action | National media >3 days’ coverage  Local MP concern  Questions in the House | Full public enquiry  Public investigation by regulator |
| Compliance Inspection / Audit | Non-significant / temporary lapses in compliance / targets | Minor non-compliance with standards / targets  Minor recommendations from report | Significant non-compliance with standards/targets  Challenging report | Low rating  Enforcement action  Critical report | Loss of accreditation / registration  Prosecution  Severely critical report |

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| **Description** | **1**  **Rare** | **2**  **Unlikely** | **3**  **Possible** | **4**  **Likely** | **5**  **Almost Certain** |
| **Frequency**  **(How often might it / does it occur)** | This will probably  never happen/recur  Not expected to occur for years | Do not expect it  to happen/recur but  it is possible it may  do so  Expected to occur  at least annually | Might happen or  recur occasionally  Expected to occur at least monthly | Will probably  happen/recur, but it is not a persisting issue/circumstances  Expected to occur at least weekly | Will undoubtedly  happen/recur,  possibly frequently  Expected to occur  at least daily |
| **Probability** | Less than 10% | 11 – 30% | 31 – 70 % | 71 - 90% | > 90% |

## **Appendix 2 - SPC Icon Description**

Graphical user interface, text, application

Description automatically generated with medium confidence