The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 March 2025

Agenda item		054/25			
Report Title		Risk Management Report Q3 2024/25			
Executive Lead		Anna Milanec, Director of Governance			
Report Author		James Webb, Head of Risk Management			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients and community		N/A	
Effective		Our people			
Caring		Our service delivery		**Trust Risk Register id:**	
Responsive		Our governance	√	N/A	
Well Led	√	Our partners			
Consultation Communication		Monthly report to Senior Leadership Committee, Operational Monthly report to Executive Team Quarterly report to Audit and Risk Assurance Committee (ARAC). This report was presented to ARAC on 17/02/2025.			
Executive summary:		1. The Board's attention is drawn to the 'Effectiveness of Risk Mitigation' section. 2. There were 458 active risks on the risk register by 31 December 2024. 61 risks were closed in Q3 2024-25. 3. We are currently strengthening Divisional assurance to Risk Management Group through to ARAC and Board.			
Recommendations for the Board:		The Board is asked to: **Note** the current risk position, and the mitigation in place to ensure that Risk Management is practiced across the Trust consistently.			
Appendices:		Appendix 1: Divisional risk profile from September, October and December 2024 (Q3 2024/25) with severity breakdown. Appendix 2: Summary of the Corporate Risk Position on 24 January 2025. Appendix 3: Corporate Risk Register on 24 January 2025.			

1.0 Introduction

1.1 Divisions review their extreme risks (scored ≥15) on a monthly basis, high risks (scored 9-12) every two months and moderate risks (scored 4-6) and low risks (scored 1-4) every quarter as part of their Divisional Board meetings. New extreme risks are also presented at the Risk Management Committee (RMC), where they are made active.

1.2 The CQC Trust-wide 'Must-do' action has been closed.

2.0 Operational Risk

The table below shows the operational risk position by approval status over Quarter 3 2024/25.

Rows 1, 2 and 3 capture all open risks. Row 4 captures the number of risks recommended as accepted. Row 5 captures the number of accepted and closed risks. Row 6 captures the number of overdue risk reviews for open risks. Row 7 captures the number of overdue actions for review.

Trust Wide Risk Position by Approval Status	Oct 2024 Total	Nov 2024 Total	Dec 2024 Total	Jan 2025 Total
1. Total No. of **Active Risks** *(Risk has been acknowledged and agreed by the risk owner, the centre / divisional governance meeting / committee / specialist subject group)*	**472**	**454**	**465**	**458**
2. Total No. of **Newly Identified Risks** *(Default approval status once risk is populated in Datix and has not been reviewed by anyone other than the risk reporting officer)*	**17 (03%)**	**17 (04%)**	**14 (03%)**	**17**
3. Total No. of **New Risks awaiting Divisional/Directorate review and approval** *(Not currently 'active' - are awaiting authorisation from member of the Leadership's Team, and/or joint team decision made during a speciality/ divisional/ committee/specialist subject group meeting)*	**6 (01%)**	**7 (01%)**	**6 (01%)**	**11**
4. Total No. of **Risks Recommended as Accepted** *(Risk has reached its 'target rating' - discussions need to be had with relevant stakeholders with a view to 'accepting' the risk)*	**7 (01%)**	**6 (01%)**	**2 (01%)**	**2**
N.B. Total for rows 1, 2, 3 and 4	**502**	**484**	**487**	
5. Total No. of **Accepted and Closed Risks** *(All stakeholders have made an informed decision to take and 'accept' the risk)*	**513**	**546**	**558**	**578**
6. Total number of **Overdue Risk Reviews** for **Open risks**	**158**	**155**	**187***	**164**
7. Total number of **Overdue Actions Reviews**	**248**	**200**	**202**	**193**

***There is an increase in the December 2024 total of Overdue Risk Reviews for Open risks because of a probe into 488 open risks where accuracy of review date was manually cleansed by the Head of Risk Management – this manual search has been undertaken monthly since November 2024 to enhance data quality.

See Appendix 2 for Divisional risk profile from October, November and December 2024 (Q3 2024/25), both with severity breakdown. N.B. The total numbers in Appendix 2 are points 1, 2 and 3 in the table above added up per month. In addition, the data is live so will change throughout the month.

The table below shows the Trust's risk position via 'Risk Type' on 03 January 2025:

Type of Risk	CSS	SACC	M&E	W&C	Corporate	Total per Type
Clinical Risk	22	64	57	18	41	**202**
External Risk	0	2	0	2	7	**11**
Financial Risk	1	1	1	0	8	**11**
Operational Risk	20	29	14	19	56	**138**
Workforce Risk	15	38	24	20	29	**126**
Total per Division	**58**	**134**	**96**	**59**	**142**	**488**

1. Clinical Risk: The risk of poor patient experience and and/or poor patient safety outcomes resulting from inadequate systems and processes associated with the Trusts capacity planning, infection prevention and control, patient experience, patient safety and outcomes and research and development.

2. External Risk: The risk of direct or indirect loss as a result of a failure to comply with regulation, operate within the law and deliver on our partnership obligations

3. Financial Risk: The risk of direct or indirect loss resulting from inadequate financial systems and processes to the Trusts management of its finances, financial reporting, funding, and liquidity

4. Operational Risk: The risk of direct or indirect loss resulting from inadequate of failed internal processes and systems or from external events (including business continuity risk, change risk, health and safety risk, IG risk, IS risk, IT risk and assets risk)

5. Workforce Risk: Risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trusts workforce supply, skills and capacity, performance and retention, within an appropriate culture. This also includes our 'non-clinical' workforce.

3.0 Summary of Corporate Risk Position:

The Trust has created a Corporate Risk Register that categorises all high-level risks scoring ≥15 risk activity into the five CQC domains and aligns them to the eight categories of risk (corporate goals) – see Appendix 3. This breakdown has allowed for a thematic analysis of the risk position (we will be looking at creating a target risk score that will align with the risk appetite score).

See Appendix 3 for the detail of the Corporate Risk Register on 24 January 2025.

As a result of continued winter pressures, including challenges arising from seasonal viruses, SaTH declared a critical incident regarding the ability for the Trust to provide safe services in January 2025. Although an increase in relating risk scores was considered at this time, a number of additional mitigating actions were pledged. Challenges continue and a level of risk continues to be monitored. N.B. this could not be reflected in Corporate Risk Register.

4.0 Effectiveness of Risk Mitigation

Further to a query from the Audit and Risk Assurance Committee Chair regarding the effectiveness of mitigating and then closing extreme risks, the table below demonstrates how the controls and actions of extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout October, November and December 2024 (Q3 2024/25).

Month	Risk	Risk Status	Actions Taken to Mitigate / Close Risk ***(at 08/01/2025)***
Oct 2024	191 - EOL Aria e-prescribing inability to deliver treatment if servers not replaced in 2023	Closed	Citrix XenApp software and Microsoft Server 2012R2 Software upgraded.
	303 - Delays in access to radiological diagnostic services for both patients on a Lung cancer pathway and routine respiratory	Closed	• Issue raised at PRM to ensure execs aware of unmitigated high level of risk • Liaised with radiology to quantify extra resource coming online and re-assess risk accordingly • Demand and option available with radiology reviewed • scope other capacity • SaTH submitted bid to support with extra capacity for radiological diagnostics.
	306 - Risk of harm due to delays in access to oncology services for patients on a Lung cancer pathway	Closed	• Issue raised at PRM to ensure execs aware of unmitigated high level of risk • Liaised with Oncology service to address concerns raised • Expedited business case for molecular marker testing.
	662 - Paediatric specific electronic system to support recognition of a deteriorating child	Closed	• Procurement of electronic system providing a consistent robust way of VITALS recording the observations, alerting staff to the frequency of recording required, and flags a deteriorating patient to outreach staff within the Trust • Monitoring through regular spot checks regarding Paediatric Early Warning System (PEWS) documentation and escalation.
	305 - Level 2 patients are being admitted to respiratory wards rather than ITU/HDU/RSU	Score reduced to ≤15 - risk removed from Corporate Risk Register	Reduction in score because of no evidence of Datix incidents. Actions completed: • Joint patient escalation SOP with ITU developed • telemonitoring solution on ward 17 and 24 implemented

			• Staff asked to raise Datix incidents each time a level 2 patient is admitted to ITU
Nov 2024	862 - Insufficient Pharmacy staffing levels within Radiopharmacy	Score reduced to ≤15 - risk removed from Corporate Risk Register	Service and staffing review completed.
	32 - Failure to achieve 7 day working standard (Obs and Paeds)	Score reduced to ≤15 - risk removed from Corporate Risk Register	Paper submitted to IIC for funding to rectify this staffing shortfall and therefore fully achieve the 7 day working standards.
	1002 - Vulnerable Gynae-oncology Clinical Nurse Specialist Service (CNS)	Score reduced to ≤15 - risk removed from Corporate Risk Register	• Successful recruitment to 2-year secondment • Business Case prepared for BCRG.
	840 - Unreliable Fluid Management System - hysteroscopy	Closed	New fluid management system is in place.
Dec 2024	875 - Recruitment Freeze – Risk to W&C Division	Score reduced but still ≥15	Score reduced from 20 to 16 because: • Plan to achieve required headcount reduction delivered • Posts have been held/sacrificed in admin, secretarial roles while other clinical posts have been reformed • Vacancy control processes implemented within the division to maintain oversight of recruitment processes in line with Trust/system processes.
	725 - Insufficient theatre space for provision of Percutaneous Endoscopic Gastrostomy (PEGS) on both sites	Closed	Regular theatre space for provision of PEGS at both sites to ensure timely treatment for patients avoiding delays secured.
	1009 - Inadequate Operating lighting for surgery in Theatres 7 and 8 RSH	Closed	New lights installed.

5.0 Next Steps for Risk Management to support the change of Risk Management Culture:

- Produce annual risk management report for May 2025 Audit and Risk Assurance Committee
- Produce a triangulation report that links themes of clinical and non-clinical risks with 2023/24 data from Incidents, Claims, Complaints, Freedom to Speak Up contacts and HealthWatch Shropshire data on complaints, concerns and compliments. This is to support the Patient Safety team's current work on triangulation
- Close the outstanding recommendations listed by MIAA:
  - The role and function of RMC should be improved with a greater focus on holding the Divisions to account and assurance flows
  - The Board's refreshed Risk Appetite once approved should be linked to operational risk policy, practice and refreshed training
  - A Training Needs Analysis for Risk Management should be developed to define expectations against which compliance can be monitored
  - Divisional risk review mechanisms differed considerably and a standardised approach should be developed
  - Divisional assurance to RMC should be strengthened
  - Assurance flows to Audit & Risk Assurance Committee should be improved to allow ARAC in turn to assure the Board.

Appendices

Appendix 1 - Divisional risk profile from October, November and December 2024 (Q3 2024/25) (and January 2025) with severity breakdown:

Open Risks by Division and Level of risk	Oct 2024 LOW (1-3)	Nov 2024 LOW (1-3)	Dec 2024 LOW (1-3)	Jan 2025 LOW (1-3)	Oct 2024 MODERATE (4-6)	Nov 2024 MODERATE (4-6)	Dec 2024 MODERATE (4-6)	Jan 2025 MODERATE (4-6)	Oct 2024 HIGH (8-12)	Nov 2024 HIGH (8-12)	Dec 2024 HIGH (8-12)	Jan 2025 HIGH (8-12)	Oct 2024 EXTREME (15-25)	Nov 2024 EXTREME (15-25)	Dec 2024 EXTREME (15-25)	Jan 2025 EXTREME (15-25)	Oct 2024 Total	Nov 2024 Total	Dec 2024 Total	Jan 2025 Total	Difference Month on Month
SA&C	3	1	1	1	10	9	9	8	82	84	82	81	44	44	46	44	139	138	138	134	⇔
M&E	0	2	0	0	7	2	2	3	58	57	59	60	36	34	34	33	101	95	95	96	⇔
W&C	0	0	0	0	3	3	3	3	40	43	43	44	10	8	10	12	53	54	56	59	⇑
CSS	0	0	0	0	10	8	8	7	24	27	25	27	18	20	21	24	52	55	54	58	⇓
CORP	16	8	8	6	31	30	33	35	77	77	73	69	26	27	28	31	150	142	142	141	⇔
Total	19	11⇓	9⇓	7⇓	61	52⇓	55⇑	56⇑	281	288 ⇑	282⇓	281⇓	134	133⇓	139⇑	144⇑	495	484	485	488	⇑

Appendix 2 – Summary of Corporate Risk Register Position at 24/01/2025

Theme	CQC Domain(s)	BAF ID	Initial Risk Score	Current Risk Score (with controls in place)
Risk to the quality of care provided to patients	Safe	BAF 1 BAF 2 BAF 8	20	16
Poor patient experience	Caring	BAF 1 BAF 2 BAF 8	20	16
Overcrowding in ED	Safe / Responsive	BAF 1 BAF 2 BAF 8 BAF 10 BAF 11	20	16
Increased pressure on health services	Safe / Responsive	BAF 1 BAF 2 BAF 9 BAF 10 BAF 11 BAF 12	20	16
Insufficient staffing capacity / skills	Effective / safe	BAF 3 BAF 4 BAF 5	20	16
Inability to meet regulatory and legislative performance requirements	Well Led	BAF 8 BAF 13	16	16
Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment	Safe / Responsive	BAF 6 BAF 7b	20	16
Increasing Cyber Threat	Responsive / Well Led	BAF 7A	25	15
Poor / ageing estate	Safe / Responsive	BAF 6 BAF 11	20	16

Appendix 3 - CORPORATE RISK REGISTER 24 January 2025

Categories of risk - corporate goals
Our Patients and Community: we deliver safe and excellent care, first time, every time.
Our Patients and Community: we work closely with our patients and communities to develop new models of care that will transform our services.
Our People: our staff are highly skilled, motivated, engaged, and live our values. SATH is recognised as a great place to work.
Our People: Our high performing and continuously improving teams constantly strive to improve services which we deliver.
Our Service Delivery: Our services are efficient, effective, sustainable, and deliver value for money
Our Service Delivery: We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.
Our Governance: We are a learning organisation that sets ambitious goals and targets, operates in an open environment and delivers what is planned
Our Partners: We have outstanding relationships with our partners, working together to deliver best practice, integrated care for our communities

Risk scores	Consequence				
Likelihood	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

CQC Domain		Title	Owner	Risk Description	Caused by (operational, not strategic, causes)	Resulting in (consequence)	Initial risk score: Likelihood	Initial risk score: consequence	Initial risk score: Score	Controls already in place	Current risk score (with current controls in place): Likelihood	Current risk score (with current controls in place): consequence	Current risk score (with current controls in place): Score	Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe	1	**Risk to the quality of care provided to patients**	**DON /MD**	Quality of care experienced by patients may be below the standard tolerated by the organisation	Increased demand to healthcare services: EDs overcrowded with long waits to be seen, and insufficient flow: Insufficient support from neighbouring authorities / providers re complex care, which affects flow: Challenging substantive workforce numbers: Use of agency: Use of ageing or outdated equipment: Loss of partner services which supported the Trust, e.g. stroke rehabilitation for stroke patients at Bridgnorth: Escalation into poor environments e.g. corridors: Poor medicines management: Delays in transferring wardable patients out of ITU: Variations in the recognition, escalation and management of sepsis risk: Inability to recruit in line with requirement of consultants and speciality level doctors: Potential unavailability of financial resources	Potential for increased safety patient incidents: Poorer experience of patients, their families, and our communities; Patients waiting longer to be seen via referrals: Slow or inaccurate diagnostic test results: Compromised recovery which may result in long term social care placement: Failure to recognise the deteriorating patient in a timely manner: Delayed diagnosis by duplicate electronic records (radiology)	5	4	20	Policies and SOPs in place, including for use of escalation areas; Use of bank staff, agency staff in particular areas; Continued recruitment of specific roles; Introduction of new clinical roles and ways of working being introduced; Visiting third party (royal colleges, etc) peer reviews and reporting; Collaborative working with neighbouring providers where possible; Hospital flow protocols in place; Improved quality governance framework in place Quality Improvement Plan in place, tracked by SOAG / NHSE	4	4	16	Increase collaborative working with partners over services; Further the work relating to HTP to introduce better care models: Continue to introduce new staff grades, and roles: Continue to review, update and implement new policies, and procedures in compliance with regulatory requirements	BAF 1 BAF 2 BAF 8	645 (15), 949 (20), 963 (20), 373 (16), 535 (15), 845 (15), 861 (15), 1010 (16), 730 (20), 698 (20), 652 (25), 884 (20), 918 (15), 917 (15), 612 (15), 284 (15), 195 (16), 464 (16), 564 (16), 881 (16), 778 (15), 825 (20), 194 (16), 454 (16), 648 (20), 701 (16), 761 (16), 804 (20), 1030 (20), 912 (16), 1047 (20), 969 (16), 720 (15), 875 (16), 1007 (20), 559 (16), 347 (16), 922 (20), 904 (15), 998 (16), 996 (15), 993 (16)	CSS M&EC SA&C W&C Corp
Caring	2	**Poor patient experience**	**DON /MD**	Patients may experience delays in provision of timely care, in a suitable environment	Inability to provide timely and efficient care due to poor flow through the hospitals; Increased waiting times for elective surgery: Escalation into poor environments e.g. corridors.	Delayed clinical diagnosis and outcomes: Insufficient elective theatre capacity: ED's overcrowded with long waits to be seen; Not all escalation areas are suitable for all types of patient care, e.g. same sex.	5	4	20	Hospital flow protocols in place; Use of bank staff, agency staff in particular areas; Leadership/ manager development opportunities available; Ward environment improvement project in place; Quality governance framework in place; Quality Improvement Plan in place, tracked by SOAG / NHSE; collaborative working in place with neighbouring providers where possible	4	4	16	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to work to attract apprentice type roles: Continue to attract skills of recently retired clinical colleagues	BAF 1 BAF 2 BAF 8	845 (15), 861 (15), 652 (25), 665 (15), 195 (16), 612 (15) 194 (16), 648 (20), 630 (15), 761 (16), 1030 (20), 912 (16), 986 (20), 969 (16), 1117 (16), 720 (15), 875 (16), 1007 (20), 347 (16), 904 (15), 998 (16), 996 (15), 993 (16)	

main		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID
Safe / Responsive	3	**Overcrowding in ED**	**COO**	Increased demand on healthcare services, and lack of flow/discharges through 'back door'	Inability to discharge patients (no criteria to reside): Increasing demands upon secondary care, particularly urgent and emergency care: Challenging staffing situation and skill mix: Patients being inappropriately signposted to A&Es rather than to speciality pathways: Bed gap:	Unable to maintain clinical assessment of patients in line with policy: Flow through hospitals affected: Long ambulance waits and offloads - which may lead to offloading critically unwell patients straight into resus and starting high level care in the back of ambulances: Deteriorating patients: Unable to comply with national performance standards, e.g. ambulance offloads: Some level 2 patients admitted to respiratory wards rather than ITU/HDU/RSU	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the area; Business Continuity Plans in place for significantly increased pressures; Regular site safety calls in place 24/7: Scheduled system calls and regular engagement with partners; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Use of bank staff, agency staff in particular areas; Use of daily multi disciplinary meetings	4	4	16	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, e.g. virtual ward, etc.;	BAF 1 BAF 2 BAF 8 BAF 10 BAF 11	**918 (15), 917 (15), 612 (15), 633 (15), 195 (16), 177 (20), 881 (16), 878 (25), 464 (16), 804 (20),** 559 (16)
Safe / Responsive	4	**Increased pressure on health services**	**COO**	Increased demand for secondary care, together with poor restoration of services after COVID has affected delivery of inpatient and outpatient care.	Lack of resources in the STW ICS to deliver 7 day services: Delays in provision of tier 4 CAHMS / specialist eating disorder specialist services: Insufficient theatre space for provision of PEGS on both sites: Challenging staffing situation and skill mix:	Lack of radiology for research trials; National shortages of critical medicines: Potential patient harm and poor experience Patients may experience lack of timely intervention in their care: Flow through hospitals affected; Long ambulance waits and offloads; Longer inpatient hospital stays (NCTR)	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the patch; Business Continuity Plans in place for significantly increased pressures; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Daily nurse staffing review to make best use of available resource:	4	4	16	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, virtual ward, etc.;	BAF 1 BAF 2 BAF 9 BAF 10 BAF 11 BAF 12	**659 (16), 373 (16), 698 (20), 1021 (16), 195 (16), 612 (15), 618 (16), 769 (15), 778 (15), 628 (20), 629 (20), 648 (20), 630 (15), 761 (16), 804 (20), 720 (15), 875 (16),** 559 (16), 347 (16)
Effective / safe	5	**Insufficient staffing capacity / skills**	**DPOD**	National shortage of healthcare staffing and increased vacancies may affect the delivery of services and the standard of patient care provided	Lack of national investment into health care: Ageing workforce: NHS pension rates decreased over last few years - NHS less attractive for long term career; Potential unavailability of financial resources	Increased patient harm: Increase in patient safety incidents: Non compliance with core standards: Inability to complete pre-assessments on some high risk endoscopy patients: Failure to learn from incidents: Decline in staff wellbeing: Increase in patient complaints: Failure to respond to complaint / incident response: Staff wellbeing affected by additional workforce stress: Delays in diagnosis: Gaps in consultant rotas potentially causing delay to consultant statutory training: Unable to meet national clinical standards: Therapy services do not comply with national staffing requirements for paediatric inpatients:	5	4	20	Daily nurse staffing review to make best use of available resource: Patients managed in line with clinical need as par as possible: Increased use of bank staff: Use of agency only in specific areas: Learning and Development offer within the organisation: Choice of leadership skill development in place: Ongoing recruitment campaigns subject to front line requirements Workforce Strategy: Rotas adjusted to cover gaps; Collaborative working with the ICS; Where appropriate, patients given self management advice within the confines of remote care (virtual ward)	4	4	16	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to attract apprentice type roles: Continue to attract skills of recently retired colleagues.	BAF 3 BAF 4 BAF 5	**659 (16), 845 (15), 1010 (16), 1112 (20), 665 (15), 730 (20), 1111 (15), 884 (20), 128 (16), 633 (15), 918 (15), 231 (16), 284 (15), 1017 (15), 618 (16), 769 (15), 882 (15), 61 (16), 801 (15), 648 (20), 628 (20), 629 (20), 927 (16), 906 (16), 220 (16), 537 (20), 249 (16), 804 (20), 1047 (20), 648 (20), 875 (16), 87 (16),** 774 (15), 996 (15), 1115 (20)
Well Led	6	**Inability to meet regulatory and legislative performance requirements**	**DG**		Increasing demand on healthcare services: Insufficient staffing / leadership capacity: Poor or faulty equipment: Poor governance processes in place, policies out of date Increasing demands from regulators	Increased patient harm: Increased regulatory intervention: Regulatory fines; Legal action taken against the Trust: Financial risk due to potential regulatory fines Failure to learn from incidents	4	4	16	Ward to board governance framework in place: Policies and procedures, reflecting updates national guidance and regulations: Mandated intensive support with NHSE in place through the Recovery Support Programme. Regular communication with CQC	4	4	18	Continue to fully engage with NHSE as part of the Recovery Support Programme; Continue to engage with CQC; Continue to engage with other third party regulators, Royal Colleges, Unions, etc.	BAF 8 BAF 13	**954 (16), 535 (15), 863 (16), 128 (16), 918 (15), 917 (15), 757 (20), 825 (20), 878 (25), 648 (20), 761 (16), 986 (20), 1007 (20),** 996 (15), 993 (16), 1078 (**TBC - data warehouse risk**)
Safe / Responsive	7	**Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment**	**FD** (estates) **DS&P** (digital)		Insufficient space (estate) for some services: Escalation areas may not be fully equipped for patient care - may lack usual equipment compliance requirements; Infection control issues in some areas: No electronic system in place which is capable of monitoring whether Radiology Reports have been read or acted on: Write over / duplicate records software can be produced (radiology): Pharmacy Laura software not compatible with widows 7 or above:	Harm to patients / staff: Longer waiting times for patient / poor experience: Diagnosis delays: Poor staff morale: Risk of fire or similar outcome: Non-compliance with healthcare standards: Delays in treatment / referrals: Loss of staff or patient data;	4	5	20	Trust policies and procedures in place regarding use of hazardous equipment; Business continuity plans in place; Training provided for use of specialised equipment; Digital Strategy and work-streams in place for large scale digital upgrading. Increasing numbers of information asset owners (IAOs) being registered to ensure oversight of digital programmes.	4	4	16	Continue to ensure that policies are in place and updated to avoid consequences; Continue to communicate health and safety messages;	BAF 6 BAF 7B	**963 (20), 955 (16), 645 (15), 861 (15), 848 (15), 72 (20), 633 (15), 769 (15), 941 (16), 1030 (20), 626 (15), 728 (15), 912 (16), 989 (15), 1075 (15), 700 (15),** 443 (15), 922 (20), 645 (15), 790 (16), 998 (16), 1102 (15), 959 (16), 1078 (**TBC - data warehouse risk**)

CSS
M&EC
SA&C
W&C
Corp

Domain		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID
Responsive / Well Led	8	**Increasing Cyber Threat**	**DG (SIRO)**	Increasing risk in the potential for a cyber attack, particularly relating to ongoing political unrest	Out of date/ unsupported software and / or systems: Poor maintenance and lack of investment into old systems: Potential non-compliance with Cyber Essentials and Digital CareCert requirements: Lack of technically qualified subject experts:	IT systems lost or compromised: Potential significant data breach: ICO fines or action taken: Reputational damage: Financial loss:	5	5	25	Digital Services have invested in a system to monitor Security Patch compliance, unsupported/out of date software and NHS Digital CareCert compliance in near-real time: NHS Digital High Severity Alerts are acted upon as a priority to minimize exposure: Regular cyber awareness communications are distributed to staff to increase awareness and understanding of cyber related matters; SaTH continues to work toward full compliance with cyber essentials and NHS Digitals Data Security and Protection toolkit, both of which have comprehensive requirements with regards to cyber security Use of other NHS Digital and National Cyber Security Centre Services such as Vulnerability Management, BitSight, WebCheck and Early Warning System to ensure issues are picked up and responded to quickly.	3	5	15	Ongoing work continues. (Specific details have not been included here in order to protect the systems, but details are available on datix.)	BAF 7A	**864 (16), 499 (15)**
Safe / Responsive	9	**Poor / ageing estate**	**FD**	Some areas of the organisation's estate require upgrading, attention, or reconfiguring	Current estate means some services are fragmented and located in more than one location: Insufficient space for some services: Potential unavailability of capital resources Use of RAAC in 1980's: Copthorne Lift 54 years old and unreliable: Obsolete nurse call system at PRH ED: Door access control systems are not in use in all clinical areas:	Inability to develop teams and transfer skills: Patients have fragmented pathway: Inefficiencies in flow: Risk of increased lone working: Low staff morale: Potential disruption to service delivery by closure of hazardous areas: Financial risk: Reputational Risk: Harm to patients and staff: IPC issues: Health and Safety issues: Loss of critical services supplies: Unable to acquire regulatory certificates and licences: Reverse Osmosis System at PRH poorly located, and risk of closure of service for 28 days if area flooded, etc. Unauthorised access to clinical areas: Increasing demand for care leads to lack of appropriate office space.	4	5	20	Appointment of Interim Director of Estates: Online reporting system in place for estate concerns and issues to be reported in real time; Business cases in place for various projects / capital spending; Staff receive focussed IPC training in specific areas where this is appropriate, according to the issue; More home working for admin staff where the service allows; Patients transferred to alternative accommodation where appropriate and available; Timely, Trust-wide communications cascade in place for urgent messaging to staff for arising issues, and for communications with the public / patients; Governance processes in place for monitoring ongoing incidents	4	4	16	Continuous oversight of capital plan to endeavour for improvements to be made in a timely manner; Progress HTP, thus enabling relocation of some services to a single site;	BAF 6 BAF 11	**608 (15), 276 (20), 464 (16), 1083 (15), 630 (15), 631 (15), 728 (15), 626 (15), 701 (16), 767 (15), 1011 (20), 1034 (16), 747 (16), 826 (20), 1058 (20), 1119 (15)**

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