Cover page	
Meeting	Trust Board
Paper Title	Board Assurance Framework
Date of meeting	26 March 2020
Date paper was written	17 March 2020
Responsible Director	Interim Director of Corporate Governance
Author	Head of Corporate Affairs

Executive Summary

The Trust Board's main focus is strategic. Board members need to know the key strategic objectives and be able to identify the principal risks to achieving those objectives. Assurance goes to the heart of the work of any NHS board of directors. The provision of healthcare involves risk and being assured is a major factor in successfully controlling risk.

1. **The Board Assurance Framework (BAF).** The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives. It is an essential tool for Boards, and provides a structure and process that enables focus on those risks that might compromise its principal objectives. All Tier 2 Committees review the BAF at each meeting where they are asked to consider and report:
    - Are the BAF risks up-to-date?
    - Is the direction of travel stated current and correct?
    - Are the current risk ratings correct?
    - Is there any additional or updated content that needs to be added?

2. **Highest scoring operational risks**. Operational risks scoring ≥15 are reviewed monthly at Operational Risk Group (ORG) and form the Corporate Risk Register (CRR). The highest scoring risks (≥20) are scrutinised through the monthly Executive Performance Review Group. Information taken from the 4risk system is validated by each Care Group/Service area's governance meeting and their senior management teams then describe their approach to risk mitigation to the attending Executive Directors, committing to target dates whereby their operational risks will be reduced or closed.

Appended:

- **Attachment 1** is the updated BAF. All recommended amendments and additional content shown in purple text.
- **Attachment 2** gives reference information on risk appetite statements linked to the Trust's objectives.
- **Attachment 3** is the ORG Chair's summary of the meeting which took place on 10 March 2020.
- **Attachment 4** shows a summary of the high scoring risks (residual >15) from the CRR in March 2020

The Trust Board is asked to:

- **APPROVE** the BAF, noting any new and revised content.
- **NOTE** the process and in particular the four questions posed to Tier 2 Committees for reviewing and updating the BAF.
- **NOTE** the summary and process for the ongoing management of high scoring operational risks.

Previously considered by:	Standing item at Trust Board and all Tier 2 Committees

The Board is asked to:			
☑ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☐ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☑ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	All

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	n/a

Attachment 1 - BAF risks

Ref	Descriptor	Dir	Low-Medium-High
PATIENT AND FAMILY Listening to and working with our patients Risk Appetite: Open		=	**LOW / MEDIUM**
1186	*IF we do not have meaningful engagement and co-production with our community THEN patients will not be at the centre of everything we do.*	=	Medium
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate		=	**HIGH / MEDIUM**
1204	*IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.*	=	High/Medium
1134	*IF we do not work successfully in partnership,THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.*	=	High/Medium
1533	*IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.*	=	High/Medium
1746	*IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorating medical conditions, THEN patients will not have the best outcomes possible.*	=	High
SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities Risk Appetite: Open		=	**MEDIUM**
561	*IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity.*	=	Medium
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate		=	**HIGH / MEDIUM**
668	*IF we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.*	=	Medium
670	*IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation.*	=	High
1492	*IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement.*	=	High
1558	*IF we do not have sufficient, competent and capable Directors THEN we cannot deliver the Trust's agenda.*	=	High/Medium
1584	*IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment.*	=	High
OUR PEOPLE Creating a great place to work Risk Appetite: Open		=	**HIGH**
423	*IF we do not have positive staff engagement THEN we cannot support a culture of safety and continuous improvement.*	=	High
859	*IF we do not have a recruitment strategy and retention strategy along with demand-based rostering for key clinical staff THEN we cannot ensure the sustainability of services.*	=	High

Key

↑ Declining
↓ Improving
= No change

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
PATIENT AND FAMILY Listening to and working with our patients Risk Appetite: Open											
1186	***IFwe do not have meaningful engagement and co-production with our community THEN patients will not be at the centre of everything we do.*** **Cause:** Limited resource available to engage **Effect:** Lack of trust from our community **Potential impacts:** • Breach of legal involvement duties • Damage to Trust reputation	**Medium / High**	• People's Academy established • Young Peoples Academy launched • Public involved with TCPS • PACE (Patient And Carer Experience) Group established • Recommendations from NHSI Review of Comms and Engagement Team implemented (May-19) • People's Academy graduates have key role in TCI and RPIWs as 'fresh eyes' • Chief Communications Officer appointed (Jul-19)	Integrated Comms and Engagement Strategy	**Low / Medium =**	**1st Line** • Volunteer Strategy 10,000+ public membership • Engagement Annual Report to Trust Board (Jul-19) **2nd Line** • Macmillan engagement process Community Connector sessions (Mar-Dec-19) • Board Development session to provide strategic direction (Feb-20) **3rd Line** Winners of MES Community Engagement (May-19)		• Develop integrated Comms and Engagement Strategy (Apr 20) DCG • Seek views from community and other stakeholders on public involvement strategy (Mar-Jun 20)	Low	Trust Board	Director of Corporate Services

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1204	***IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.*** **Cause:** Lack of assurance that service failings have been addressed **Effect:** Avoidable harm to patients **Potential impacts:** • Patients choosing other providers • difficulty recruiting staff • low staff morale • difficulty retaining staff	High	• Being Open and Duty of Candour policy • Revised Incident reporting policy • Review meetings to review incidents, legals and complaints & SIRG • VMI - Value Stream 5 (Patient Safety) • Actions taken in response to CQC inspection • Temporary inpatient closure of MLUs (Nov 18) • Director of Midwifery (DoM) and new Care Group Director now in post • Statutory training monitored - 90% compliance (Dec-19) • Clinical Feedback monthly meeting in place for learning from complaints/Datix/SIs • Daily safety huddles in place		Medium / High =	**1st Line** • Maternity outcomes dashboard **2nd Line** • Maternity & Neonatal Safety Collaborative etsablished • Linked with Princess Alexandra Hospital Harlow (Jan-19) • Established Maternity Task Force Committee chaired by Trust Chair - (Feb-19) • CQC Engagement meetings - submission of section 31 review weekly with sign off by DoM/CGD/DDoN • Fresh Eyes Report by Interim Strategic Midwife. • Working with the Local Maternity Systems to implement national strategic plans such as Better Births. **3rd Line** • GIRFT (Get It Right First Time) most recent position • Maternity CQC visit April 2019 by Ted Baker • CQC full review Nov 2019 - positive feedback received. Final report due March 2020.	• Secretary of State review – expanded and delayed & open book review • CQC Inspection and Conditions letter (Nov-18) • CQC Report pending March 2020 • Adequate assurance and governance processes within Care Group following CNST review • Gaps in bereavement services as highlighted in Maternity review interim report • Lack of assurance around culture change and willingness to be open with families and learn from incidents	• Establish W&C ISG as part of QIP (DTS Apr-20) • CNST Incentivisation Action Plan (Mar-20) •Review of Governance and assurance for CNST with DoM as accountable officer (Mar-20) • Full review of Bereavement services in collaboration with SANDS to take place (Mar-20) • CCG MLU Consultation imminent • Complete Action Plan for Independent Maternity Review emerging trends (Mar-20)	Low	Maternity Taskforce Committee	Director of Nursing, Midwifery and Quality Chief Operating Officer
	MBRRACE results	M		MBRRACE results	M			MBRRACE results	L		
	SoS Review progress	H		SoS Review progress	H			SoS Review progress	L		
	Maternity CQC Patient Survey	M		Maternity CQC Patient Survey	L			Maternity CQC Patient Survey	L		
	Maternity Dashboard	H		Maternity Dashboard	M			Maternity Dashboard	L		

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SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1134 1369 1158 1197 1235 1426 1585 105	***IF we do not work successfully in partnership,THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.*** **Cause:** Lack of a joined-up approach with Local Health Economy **Effect:** Failure to achieve performance and quality targets **Potential impacts:** • Poor experience for patients – delays & moves • Additional patients on wards with additional staffing costs • Reduced quality of care (sepsis, ED delays) • Low staff morale • Increased levels of Delays in Transfers of Care • Increased ambulance handover delays • Reputational damage • Clinical Safety Challenges • Recruitment and retention problems	High	• SaTH Escalation policy & Hospital Full Protocol • Weekly LHE COO meetings Shropshire, T & W A&E Delivery Board and Group • TCI/TCPS - Value Stream 1 Respiratory Ward Discharge roll-out - Value Stream 8 (ED process) LHE Winter Plan (Sep-19) • Twice daily discharge hub meetings. Daily DTOC report • LHE Complex Discharge Escalation process. • SAFER programme • Operational Capacity and Resilience Plan in place; - SaTH2Home - Red 2 Green	• Unable to staff escalation wards with substantive staff • Ward capacity at RSH and PRH • 7-day working not in place throughout service • Pre-noon discharge below NHS target 33% (SaTH at 15%) • Lack of Microbiology consultants • At times of high operational pressure, some patients can only be accommodated in contravention to Escalation Policy	Medium / High =	**1st Line** • Meeting DTOC target of 3.5%. • Ward 35 - planned (Nov-19) • ED performance is showing slow recovery (but not at rate planned) • Orthopaedic capacity realigned at PRH (Jun-19) COO • 7 Day Framework presented to Board Jul-19) • Minors performance improved from 86.9% Mar 18 to 98.1% (Mar-19) **2nd Line** • STP update – Urgent Care, Frailty and Winter Planning Programme underway • Out of Hospital Programmes (Shropshire Care Closer to Home, T&W Neighbourhood Working) (Sep-19) • Review of Shropshire Community Services (Aug-19) - linked to STP work programme **3rd Line** • Continued reduction in falls, below national levels (Dec-18) • Reduction in super stranded and stranded patients (now in top quartile Maintained 21 - Q2 2019) • ECIST Review (Mar / Jun-19) • RAMI performance	• CQC inspection - Inadequate (2018) • Not delivering criterion-led discharge • Escript not joined up • CQC Inspection ED condition letter (Sep-18) • Complex Discharge internal audit - Deloitte (Limited Assurance) (Feb 19) • CQC Reg 31 Letter (Mar-/Nov 19) • Workforce Cttee 7 Day Working Assurance update (Jun-19) • National Stroke Audit (Jun-19) • Infection Control escalated Red (Feb 19) confirmed (Jun-19) • Current ED performance remains below national average (Jun-19)	• STP Recovery plan to deliver 4 hour target includes target of 85% patients being discharged within 48 hours (Mar-20) COO • 7 Day Working Action Plan (Jun-19) WD Transfer SaTH 2 Home to Local Authorities Sept 19 CEO • Establish A&E Oversight Group Jul-19 DCE • A&E Delivery Board support to PRH capacity includes review of stroke rehab pathway.	Low	Quality & Safety	Chief Operating Officer
	ED 4hr Target	H		ED 4hr Target	H			ED 4hr Target	M		
	Super-stranded performance	M		Super-stranded performance	L			Super-stranded performance	L		
	Risk Adjusted Mortality Index (RAMI)	M		RAMI	L			Patient mortality - RAMI	L		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1533	***IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.*** **Cause:** Lack of sustained improvement **Effect:** Patients do not receive safe, high quality care **Potential Impacts** • Remain in special measures • Increased regulatory and press scrutiny • Damage to reputation which impacts upon recruitment, clinical effectiveness and safety. • Staff retention/survey results deteriorate. • User surveys deteriorate	High	• ISG and Improvement Governance structure in place (Jan-19). Chaired by NQN from Sep-19 • QIP Plan agreed (Mar-19) • Two weekly reporting for QIP established (Mar-19) • Weekly reporting each week to NHSI/CQC against regulatory enforcement notices, providing progress on action plan. Signed off by CN & MD and CGTriumvirates. • Monthly Safety Oversight and Assurance Group (SOAG) meeting with system partners established (Feb-19) • SaTH PMO team in place (May 19) KPIs (high-level and root cause level) developed and reported against (May-19) • Extra midwife sessions in place (Sep-19) • Internal review of existing QIP / must and should dos. • Review of governance structure for CQC Quality iMprovement Plan underway with Interim DON and Director of Strategy and Transformation • Submitting section 29 and 31 weekly		Medium / High =	**1st Line** • Monthly QIP update reports to TB • Monthly updates against s29 and s31 regulatory notices to CQC & NHSI • Maternity (Feb-19) 90% complete (16/20) • Well-Led sessions with Board and SLT (Feb-19) • DOM appointed (Jul-19), commences Nov-19. • Immediate action implemented to address additional CQC concerns (Dec-19) • Sign off by care group triumpheerate weekly and oversight before uploading to CQC Portal by DDON then sign of by DCN, MD and COO • Governance reviewed and approved at Execs (Dec-19) to be implemented in line with diaries January 20 **2nd Line** • Engagement and Enablement Group to link to wider staff engagement agenda • Improvement Steering Groups established. • QIP Action plans finalised (Apr-19) • Progresss against CQC 'Must Dos' and 'Should Dos' • Weekly reporting to CQC for additional s31 notice (Dec-19) **3rd Line** • Monthly Scrutiny Oversight and Assurance Group established with system partners.	• Full compliance and achievement in section 29 (ED) & 31 (Mar-19) • Robust PMO to support QIP • Key leadership role gaps (Director of Nursing) to oversee s29 and 231 reporting • Additional S31 notice (Nov-19) covering: - Patients presenting wiith possible sepsis or a deteriorating medical condition - De-escalation management and intervention holds - Management of minors through ED pathway • Limited capacity in nursing and operational care groups at ward/service level to consistently undertake required audits	• PMO review into s29 and s31 reporting ownership and responsibilities • Working with NHSI Improvement Director & Execs to strengthen QIP and PMO approach. • Refresh of QIP Governance arrangements. • Additional actions to be added to QIP to address s31 notice (Dec-19) • Monthly CQC engagement meetings to commence after well led as advised by CQC on request of an update from Trust interim DON • CQC Improvement Plan and sections 29 and 31 currently being aligned to transformation programme • Developing a case and sourcing additional nursing resource and expertise to support at corporate and operational level to drive improvements at pace • Planning to introduce nursing quality and patient safety metric performance, outcome focused learning and assurance meetings by DON with HON from ward to board from February 20	Low	Quality & Safety	Director of Nursing, Midwifery and Quality
	Progress against s29 action plan	M		Progress against s29 action plan	L			Progress against s29 action plan	L		
	Progress against s31 action plan	H		Progress against s31 action plan	H			Progress against s31 action plan	L		
	Progress against full action plan	H		Progress against full action plan	H			Progress against full action plan	L		

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SAFEST AND KINDEST Patients and staff feel they were safe and received kind care Risk Appetite: Moderate											
1746	***IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorationg medical conditions, THEN patients will not have the best outcomes possible.*** **Cause:** • National process, SOP and flow chart not consistently followed • Inconsistent corporate function for sepsis education and deteriorating patient intervention - due to staffing and no 24/7 service offer • Inconsistent application of the NEWS scoring across different clinical areas **Effect:** Poor patient outcomes **Potential Impacts** • avoidable harm caused to patients • mortality rates will increase • damage to reputation which impact on public confidence,staff recruitment and safety • CQC will escalate enforcement action and Trust will remain in special measures	High	• Sepsis nurse appointed (Jun-19) • Critical care outreach team • NEWS2 system in place across Trust with estbalished escalation process • Sepsis Six bundle and screening tools in place supported by Sepsis Nurse and Critical Care Outreach Team	• Lack of clarity around escalation process used by HCAs, RNs and Medical staff • PSAG does not prioritise NEWS2 score >3 • Lack of consistency in following/escalating in line with established process • Lack of resource to respond to escalation effectively	High	**1st Line** Daily checks and audits in line with CQC and escalation process - daily feedback graphs by wards / areas **2nd Line** • Sepsis Value Stream • Weekly Matrons check • Weekly Peer Audit and quarterly Clinical Audit **3rd Line** • Performance against Sepsis CQUIN • CQC Insight position	• Cultural response and engagement of frontline staff to implementation • Lack of single overaching plan for deteriorating patient (inc. sepsis) with clear SOPs and consistent documentation	• Form 24/7 Medical Emergeny Team -MD (Jan-20) • Introduce Clinical Champion/Improvement Manager to educate and raise concerns of DP/NEWS2/Sepsis 6 - MD (Jan-20) • Reinstate Nurse Alert course - DNMQ (Feb-20) • Update overarching policy for deteriorating patient with clear escalation processto.formalise documentation and outcome of reviews following escalation to ensure fitness-for-purpose and establish lines of accountability - MD (Feb-20) • Develop PSAG protocol to identify high risk patients • Resource and appoint medical DP champion to work together with sepsis nurse. • Coaching of clinicians by yet to be confirmed medical DP champion • Respond to new Sepsis/DP CQUIN being introduced for 20/21 - MD (Apr-20) • Audit Action Plan and respond - D-DNQ (Mar-20)	Low	Quality & Safety	Medical Director
	% patients screened for sepsis using the Trust screening tool vs target	H	% patients screened for sepsis using the Trust screening tool vs target	H		% patients screened for sepsis using the Trust screening tool vs target	L				
	% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	H	% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	H		% sepsis patients receiving antibiotics within 60 minutes of diagnosis vs target	L				

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SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities Risk Appetite: Open											
561	***IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity.*** **Cause:** Lack of system-wide effective processes **Effect:** Poor /unsafe patient care & experience **Potential impacts:** • Financial penalties • Performance notices • Failure to receive STF allocation • Additional patients on wards	High	• LHE Winter Plan (Sep 19) • Whole health economy surge plan in place and monitored closely. • NHSI monthly Performance Review Meeting (PRM) and Quarterly Reviews • Clinical Quality Review Meeting with Commissioners • SAFER programme /standard work value stream • Frailty Project • TCI/TCPS – Value Stream 4 (Outpatients) -Value Stream 8 – Surgical Pathway -Value Stream 7 – CT Scans • Reconstitution of Cancer Board (Mar-19) • SaTH / CCG Planned Care WF	Workforce challenges and demand in - Urology - Breast - Anaesthetics National NHS pension challenge restricting some medical staff - WLI / additional PAs.	Medium =	**1st Line** • RTT Recovery plans for non-compliant specialties • Lung Cancer Pathway undergoing TCPS treatment **2nd Line** • Reduction in super stranded patients – now in top quartile • 99% patients received diagnostics within 6 weeks (Jun-19) • Cancelled Operations increased RTT position **3rd Line** • Current DNA and 30 day readmission performance exceeds peer median and national median • CHKS Top 40 Hospitals for sixth consecutive year (Oct-19) • Cancer Patient Survey (Sep-18) • 31 day cancer currently 97.1% against target 95% (Mar-19) • 2 week target currently 89.7% against target 95% (Mar-19) • Diagnostics 99.88% against 99% target (Jun-19)	• 14 day Cancer target pressures • RTT remains below 92% 2/52 and 62 day cancer remains challenging - pressures in Breast and Radiology, Urology, Lung and Colorectal • Anaesthetics staffing pressures.	• Urology links being developed with UHNM - ongoing COO • Planning 2 week recovery with NHSI July 19 COO • RTT Recovery Plans COO • 62 day target recovery (by Dec-19) COO Winter planning - capacity funding envelop (SaTH/CCGs).	Low	Performance	Chief Operating Officer
	Diagnostic target	M		Diagnostic target	L			Diagnostic target	L		
	Cancer waiting times	H		Cancer waiting times	M			Cancer waiting times	L		
	RTT Targets	H		RTT Targets	M			RTT Targets	L		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
670	***IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation.*** **Cause:** Inability to invest in development of services **Effect:** Potential lack of financial control **Potential impacts:** • Impacts on cash flow and borrowing requirement • Investment required to improve efficiency • Poor patient experience	High	• Capital planning process and prioritisation • Risk based approach to replacement of equipment • Confirm and challenge meetings with Care Groups	Performance management of adverse variance to Plan Pay and non pay controls Budgetary control and performance	High =	**1st Line** • Financial component of performance report (monthly TB) • Procurement CIP delivery **2nd Line** • Financial Improvement Board meets monthly • Workforce and Non-Pay Panels established **3rd Line** • External Audit (KPMG) • Internal Audit (Deloitte)	• S30 report on 2018/19 annual report and accounts • 2019/20 financial position adverse to plan by £1.8m at month 6 on an underlying basis • CIP of £18.9m not fully identified at Month 6 • Historic and on-going liquidity problem • Recurrent deficit of £29m Mar-19 Draft forecast outturn shows risk verses control total inc. PSF of c. £14m • Potential cash shortfall risk (Q3) Agency and non-pay overspend (Sep-19)	• Progress against operational plan to be regularly reported to Trust Board – ongoing COO • Deloitte commissionned to undertake CIP financial advisory project • Pay and non pay controls to be reviewed • Accellerate action undertaken at CIP schemes	Medium	Performance	Finance Director
	Cost improvement Programme	H		Cost improvement Programme	H			Cost improvement Programme	M		
	Shortfall in liquidity	H		Shortfall in liquidity	H			Shortfall in liquidity	M		
	Shortfall in I&E	H		Shortfall in I&E	H			Shortfall in I&E	M		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
1584	***IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment.*** **Cause:** Lack of investment funding **Effect:** Inability to invest in Trust infrastructure **Potential impacts:** • Lack of funds to invest in improving the environment and modern equipment• Poor patient experience	High	• Capital Planning process • Risk based approach • Prioritised backlog list May 19 • Associate Director of Estates in post (Oct-19) • Annual 6 Facet Survey • Annual Review of medical devices backlog • Decontamination plan being finalised for both sites	• Insufficient funds to modernise estates, equipment • No rolling maintenance replacement programme for Estates/equipment • No site development plan	High =	**1st Line** • Qualitative Design Review Copthorne Building (Mar-19) • Monthly Estates Report to Trust Board (Apr-19) • Investment in reducing highest rated risks approved (Apr-19) **2nd Line** • Diagnostic equipment Lease Purchase approved (Jun-19) • Contract Award for CT Scanners for PRH Lease Purchase approved (Jun-19) • Capital allocated by NHSI to increase winter capacity (Mar-19) • Emergency capital confirmned for fire improvement works - Copthorne Building (Nov-19) • Draft Estates site plan (Jul-20) **3rd Line** • Oakleaf six facet survey • Building Control sign off on W35 (Mar-20) • Alteration Notice W18 Lobby area (Mar-20)	• Comprehensive phased medical equipment, devices and Estates prioritised and risk assessed replacement plan not in place	• Appoint additional Compliance and Fire Safety Officers (Jan-20) • Need to finalise Estates Strategy (Sep-20) • Need site development plan (Jul-20) • External Review of Compliance and control functions (Apr-20) • Expedite asbestos re-Surveys (Apr-20)	Medium	Sustainability	Director of Corporate Services
	Equipment Priority List	H		Equipment Priority list	H			Equipment Priority list	M		
	Estates High Risks	H		Estates High Risks	H			Estates High Risks	M		
	Result of 6 Facet Survey	H		Result of 6 Facet Survey	H			Result of 6 Facet Survey	M		

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LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
668	***IF we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.*** **Cause:** Delays in delivering the agreed programme **Effect:** Unsustainable services **Potential impacts:** • Suboptimal use of scarce workforce resource • Additional costs arising from current service reconfiguration • Inability to attract essential staff	High	• Programme resources in place • SaTH Sustainability Committee to oversee implementation Hospitals Transformation Programme (HTP) • STP wide Independent Oversight Group (IOG) established to oversee delivery of the acute (HTP) and community programmes • NHS Transformation Unit supporting HTP in Programme Director role • Appointment of Director of Strategy & Transformation and Associate Director of Transformation (Sep-19) • HTP timeline for delivery revised and agreed • Project governance revised and agreed • Draft SOC submitted (Nov-19)	Severe shortages of key clinical staff required to sustain clinical services	Medium =	**1st Line** • CEO chairing HTP Group (Feb-19) • SOC approved by Trust Board (Feb 19) • Increase in number of ED consultants appointed since announcement of capital funding for HTP • OBC in development (Mar-19) **2nd Line** • 3P event held 50 senior clinicians output to inform OBC development completed (Mar-19) • Programme Director commenced to oversee delivery of the OBC (Sep-19) • Associate Director of Service Transformation in post (Oct-19) • Clinical Strategy development workshop (Oct-19) **3rd Line** • Post Consultation Business Case (PCBC) approved by a Joint Committee of the CCGs (Jan-19) • IRP response received with recommendation to progress (Oct-19)	Awaiting feedback on SOC (Jan-20)	• Board OBC workshop (Aug-19) - Reviewing options including inflation costs and scope - Review options for multi-story car parking and Energy Centre	Very Low	Sustainability	Director of Transformation and Strategy
	Preferred option agreed	M		Preferred option agreed	VL			Preferred option agreed	VL		
	Outline Business Case approved	H		Outline Business Case approved	M			Outline Business Case approved	VL		
	Full Business Case approved	H		Full Business Case approved	H			Full Business Case approved	VL		

Risk ID	Description	Inherent	Current Controls	Gaps in Controls	Residual	Assurance	Gaps in Assurance	Further Planned Actions	Target	C'ttee	Owner
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions Risk appetite (transformation) : hungry Risk appetite (finance): moderate											
1492	***IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement.*** **Cause:** Lack of a joined-up approach to delivery **Effect** Inability to drive, underpin or sustain clinical improvements **Potential impacts:** • Risk of missed patient test results, resulting in missed or late treatment • Not having immediate access to all relevant patient information • Compromise of overall interoperability and transformational agenda	High	• Working towards definitive list of Trust systems • Working towards implementation of Digital Change Control Board (DCCB) and associated underpinning documentation • Associate Director of Digital Transformation in post • Cyber security function recruited	• No current Digitisation Strategy • No Director-level lead across both IM & IT • OS upgrade required on c.500 devices to ensure continuity of Windows updates	High =	**1st Line** • Updates quarterly to Sustainability Committee • Digital Steering Committee and Digital • Change Control Board established • Board/SLT Session on Digitisation (Feb-19) **2nd Line** • Board session with NHSE Regional Directors (Jun-19) • Board Session on Digitisation (Jun-19) with NHSE to agree priorities • Board development session on cyber security (Oct-19) **3rd Line** NONE	• PA review of infrastructure and EPR readiness (Feb-19) • NHS Digital Trust System Support Model (TSSM) team review (Jun-19): - current infrastructure - PA infrastructure report - minimum requirements to ensure stable infrastructure	• Windows 10 upgrade (2019/20) DCG • Consider Medical Records Strategy to prepare for EPR (Sep-19) - DCE • Prioritisation & assessment of IT projects currently in flight through to early stages of working up, in context of team capability and capacity (Oct -19)	Low	Sustainability	Finance Director
	IT digitisation strategy approved	H		IT digitisation strategy	H			IT digitisation strategy in place	VL		
	Outline Business Case for EPR and infrastructure approved	H		Outline Business Case for EPR and infrastructure approved	H			Outline Business Case for EPR approved	VL		
	Full Business Case for EPR and infrastructure approved	H		Full Business Case for EPR and infrastructure approved	H			Full Business Case for EPR approved	VL		

Risk Appetite statement by objective

Risk appetite is the level of risk the Trust will take in pursuit of its objectives

Trust Objectives	Risk Appetite Statement	Appetite (level)
1 Listening to and working with our patients and families to improve healthcare	*The Trust is keen to consider all delivery options and select those with the highest probability of productive outcomes even when there are elevated levels of associated risk*	4 Open
2 Our patients and staff will tell us they feel safe and received kind care	*The Trust will support innovation with demonstration of commensurate improvements in outcomes. Systems / technology used routinely to enable operational delivery.*	3 Moderate
3 Working with our partners to promote 'Healthy Choices' for all our communities	*The Trust is prepared to take decisions that are likely to bring scrutiny but where the potential benefits outweigh the risks. Value and health benefits will be considered, not just cost and resources allocated to capitalise on opportunities.*	4 Open
4 a) Innovative and Inspiration Leadership to deliver our ambitions (transformation)	*The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk*	5 Hungry
4 b) Innovative and Inspiration Leadership to deliver our ambitions (finance)	*The Trust is prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.*	3 Moderate
5 Creating a great place to work	*The Trust will encourage new thinking and ideas that could lead to enhanced staff engagement*	4 Open

Risk Appetite definitions

1	**Averse:**	Avoidance of risk and uncertainty is a key organisation objective.
2	**Minimal:**	Preference for ultra-safe options that are low risk and only have a potential for limited reward.
3	**Moderate:**	Preference for safe options that have a low degree of risk and may only have limited potential for reward.
4	**Open:**	Willing to consider all potential options and choose the one most likely to result in successful delivery, while also providing an acceptable level of reward and value for money.
5	**Hungry:**	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

The Shrewsbury and Telford Hospital NHS Trust

Operational Risk Group Summary

To **RECEIVE** and **NOTE** the Committee Chair's report of the 3-4 issues/key points from the meeting which are escalated to the Tier 2 Committees

Key points from the meeting held on 10/03/2020

1. Existing risks with increased risk score

- **CRR 1747 - Contaminated Fluid Waste Management** (**revised residual score 16**)
  This risk pertains to the management of fluid used for Urology procedures; specifically with respect to the current system/equipment (c.20 years old), manual handling and disposal of contaminated fluid and monitoring of input/output fluid. An incident relating to fluid counts was recently reported on the Datix system. A business case to replace the equipment describing significant quality and cost benefits is being worked up by the management teams.
- **CRR 1363 Diminishing Quality of Ultrasound Heart Scan Machines** (**revised residual score 20**)
  Ultrasound Image quality and reliability issues increasing the risk of negative quality, safety and performance impacts on cardiac patients reviewed within the Emergency Department. In tandem with CRR1535/6 (below), a Joint Review and Business case is being developed with the Radiology Service to explore a managed Ultrasound service programme.

Level of assurance provided: ***Moderate*** ***Direction of travel:*** ***Worsening***

2. New Risks added to the Corporate Risk Register (CRR)

- **CRR 1535/6 – Ageing Ultrasound scanners at PRH** (**residual score 20**)
  This risk pertains to the management of fluid used for Urology procedures; specifically with respect to the current system/equipment (c.20 years old), manual handling and disposal of contaminated fluid and monitoring of input/output fluid. An incident relating to fluid counts was recently reported on the Datix system. A business case to replace the equipment describing significant quality and cost benefits is being worked up by the management teams.
- **CRR 1640 Single handed Transplant Nurse (residual score 20)**
  The service has just one Transplant nurse with no cover for periods of annual leave or unexpected sickness. The team dedicated to the transplant service is insufficient to support timely access to transplantation. Poor access to transplantation was highlighted in recent GIRFT review.
  Post meeting note: The Care Group has been requested to provide clarity on the risk score further to developments and discussion at USCG Board
- **CRR 1685 – Passed maximum waits – Renal** (**residual score 15**)
  Within Renal Services there are currently 465 patients on the outpatient pending list who are showing as not having been seen for follow up within the time range specified by their clinician. The actual number is believed to be smaller than this due to data error issues generated by SEMA.
- **CRR 1751 – Compliance Structure & Resources – Estates (residual risk score 20)**
  Lack of suitably qualified and skilled workforce required to deliver safety and compliance assurance across the estate resulting in a failure to assure compliance across estates functions and potential patient and staff harm.

Level of assurance provided: ***Moderate*** ***Direction of travel:*** ***Same***

3. Closed risks

A total of 7 risks have been closed over the last period. Of these, the high-rated risk closed was:

- **CRR 714 - Replacement of Theatre operating lights at RSH (residual score 20)**
  Closed by Kevin Lloyd: *Generic risk split into individual risks for each light.*

Level of assurance provided: ***Moderate*** ***Direction of travel:*** ***Same***

4. Matters arising

- Members were pleased to note theatres as an example of an area where fostering a culture of transparency and openness in reporting risk is apparent.

Level of assurance provided: ***Moderate*** ***Direction of travel:*** ***Improving***

Completed by: **David Holden; Chair of Operational Risk Group**
Date: **10 March 2020**

CORPORATE RISK REGISTER – SUMMARY*
Prioritisation of Validated Operational High-rated Risks
Residual scoring range ≥15 at 10/03/20

KEY: ↑ risk increasing ↓risk decreasing = no change in last period
To be ordered / otherwise being resolved

Risks rated 25

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
None							

Risks rated 20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1586	Anaesthetics Theatres & Critical Care **W**	1	Lack of Consultant Anaesthetists cover at PRH impacting on the ability to maintain an out of hours anaesthetic department which if not resolved will have impact upon all other service - both planned and unplanned within the hospital. This means that there is no consultant cover supervising junior anaesthetics colleagues, no obstetric anaesthetics consultant cover, no cover for critically ill Paediatric cases, no cover for emergency airway situations, and no consultant cover in the event of a major incident. *Controls: ACAs offered to all existing Anaesthetists* ***Assurances: Continue to source support Cross site***	Not applicable	**20 =**	**11/6/19** *(10/5/19)*	18/2/20
1122	Emergency Assessment **W**	2	Lack of Middle Grade Medical cover in ED. Shortage of middle grade doctors is giving risk to safety and financial risks. 14/24 posts currently filled. *Controls: additional locum Consultant cover in place* ***Assurances: Overarching recruitment trajectory in place.***	Not applicable	**20 =**	**06/09/16** *(22/8/16)*	09/03/20
949	Theatre, Anaesthetics & Critical Care **W**	3=	Non-compliance with Critical Care standards for Intensivist cover within ITU. *Controls: RSH split rota now in place with intensivists solely on rota to cover ITU/HDU departments. to ensure 24/7 cover.* ***Assurance: Recruitment plan in place. New rota offering increasing cover to PRH ITU.***	Not applicable	**20 =**	**05/05/15** *(20/1/15)*	23/02/20
1620	Pathology Centre **Q**	3=	NPSA Safety alert 16: Early Identification of failure to act on Radiological Imaging Reports. *Controls: Radiologists will contact the referring team or relevant equivalent for findings that require immediate intervention* ***Assurance: All reports are made readily available within PACS, Review, Clinical Portal and CRIS as well as paper copies being posted out to the referrer. All unexpected findings include an NPSA alert tag within the report text to flag to the referrer***	Not applicable	**20 =**	**1/08/19** *(1/7/19)*	17/02/20
1547	Chief Operating Officer **S**	5	Digital Dictation Hardware and Software Equipment is failing and no continuity plan is yet in place. ***Assurance: Revert to manual recording of patient consultations (limited assurance)***	c.£115k (plus PM resource to deliver)	**20 =**	**12/03/19** *(15/2/19)*	31/01/20

**The full detailed risk registers are available from 4risk - https://sath.insight4grc.com/Risk/Home.aspx*

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1084	Ophthalm -ology **Q**	6	Ophthalmology patients waiting longer than the recommended follow up time may come to harm. There have been a number of reported incidents *Controls: 3rd party providers provide additional capacity. Past Max to wait report to ensure accurate recording* ***Assurances: Complete review of workforce in line with demand v capacity analysis. This will inform the need for additional resource.***	Not applicable	**20 =**	**11/09/18** *(1/3/16)*	07/01/20
1075	Estates **S**	7	Estates Condition (6 facet) surveys have highlighted a number of significant risks across both sites. *Controls: CPG to prioritise funding based on areas of highest risk.* ***Assurance: 6 facet survey being refreshed to reprioritise areas for funding***	RSH (Condition & Statutory) High Risk: £5.61m PRH (Condition & Statutory) High Risk: £366k (gross)	**20 =**	**01/03/16** *(1/3/16)*	24/09/19
1751	Estates **W**	8=	Compliance Structure & Resources. Failure to assure compliance across estates functions and potential patient and staff harm. *Controls: Regularly gather compliance action plans and highest risk and prioritise actions with highest impact.* ***Assurances: Commissioning external contractors to provide assurance through surveys/audits***	Not applicable	**20 NEW**	**10/3/20** *(6/1/20)*	-
1715	Director of Nursing and Quality **Q**	8=	De-escalation management and intervention holds on all patient and in all departments are not completed in line with National Guidance *Controls: increased staff awareness, audits, daily incident reports, Safety Holding Group established.* ***Assurance: Comprehensive s31 plan in place***	Not applicable	**20 =**	**17/12/19** *(16/12/19)*	02/03/20
1640	Medicine **W**	10=	Single Handed Transplant Nurse/access to transplantation. The team dedicated to the transplant service is insufficient to support timely access to transplantation. Poor access to transplantation was highlighted by GIRFT Controls: *Additional 6 hours bank nurse/week* ***Assurance: Management team developing business case to increase transplant service provision through repatriation of activity from UHB.***	Not applicable	**20**	**10/3/20** *(20/9/19)*	18/2/20
1573	Pathology Centre **W**	10=	Microbiology Consultant capacity to meet service requirements Controls: No controls identified ***Assurance: Development of Consultant Clinical Scientist, approach potential locum, approach neighbouring Trusts for support***	Not applicable	**No res'l score (inh't. 20) =**	**16/4/19** *(18/3/19)*	03/02/20
1468	Surgery **W**	10=	Urology Demand & Capacity Mismatch. Significant Work Force Challenge Controls: Additional capacity scheduled and extra theatre sessions secured. ***Assurance: Continue development and training of Trust Middle Grade doctor to undertake independent practice in TRUS biopsy***	Not applicable	**20 =**	**23/8/18** *(31/7/18)*	14/01/19
1318	Emergency Assessment **W**	10=	Nursing staffing levels in ED at PRH and RSH Controls: Rotational programme, block booking agency, international recruitment initiatives etc ***Assurance: Lead Nurse for Operations in ED in place for 6 months from Jan-19***	Not applicable	**20 =**	**18/12/18** *(1/11/17)*	31/12/19
830	Theatres Anaesthetics & Critical	10=	Theatre lights in RSH and PRH Theatres The operating lights are coming to the end of their life	£30k per Theatre	**20 =**	**31/7/13** (6/8/13)	23/02/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
	Care **S**		and are beyond repair. This could impact on patient safety. There are financial costs associated with hiring temporary lights. No opportunity to move lists between theatres if lights fail *Controls: Mobile lights can be hired* ***Assurance: Escalated at ORG and to be discussed as priority at Capital Planning Group***				
1345	Corporate **S**	10=	Patient hoists – passive hoists fitted with actuators: ageing stock and reliability issues *Controls: Regular LOLER inspections.* ***Assurance: Limited***	£300k	**20 =**	**13/2/18** *(13/2/18)*	02/12/19
748	Radiology **W**	10=	Lack of Breast imaging specialists impacting on viability of breast screening service *Controls: Re allocation of the Breast Radiologist's general commitments; skill mix review* ***Assurances: Issue covered in 'Services in Spotlight' paper to Board. Outcome of SSP will impact on this risk as will result in single site working***	Not applicable	**20 =**	**03/09/13** (*27/7/13*)	10/02/20
1363	Cardiology **S**	10=	Diminishing Quality of Ultrasound Heart Scan Machines *Controls: Regular maintenance is carried out to try and keep the machines functioning to the best of their ability.* ***Assurances: Business Case for equipment replacement being developed by management teams in conjunction with Radiology***	tbc	**20 ↑**	**2/9/19** (*5/3/18*)	31/7/19
1535 1536	Radiology **S**	10=	Ageing ultrasound scanners at PRH *Controls: Regular QA by external service agent* ***Assurances: Business Case for equipment replacement being developed by management teams in conjunction with Cardiology***	tbc	**20 ↑**	**12/6/19** *(18/12/18)*	17/2/20
817 807	Trust wide **W**	19=	Failure to recruit nurses to fill Trust-wide vacancies resulting in staffing issues. *Controls: Risk controlled by use of bank and agency but results in increased costs; Escalation Policy; Creation of new roles for nursing; 'Golden ticket'* ***Assurance: On-going recruitment events –national shortage of nurses with about 5% overall vacancy rate but up to 35% in some areas. Development of programme of roles to support nursing***	Not applicable	**20 =**	**28/11/13** *(26/9/13)*	06/02/20 16/01/20
1313	Therapies **W**	19=	Reduced in-patient therapy staffing levels caused by vacancies and staff sickness means the service is only to operate at the level of a bank holiday service. *Controls: agency physio; job reallocation* ***Assurances: Locums continually being sourced for interim cover arrangements***	Not applicable	**20 =**	**14/1/19** *(15/9/17)*	03/03/20
1236	Ophthalmo -logy **W**	19=	Consultants in Ophthalmology Shortage of key clinical staff are making service provision difficult. The department has had some significant challenges in recruitment and retention of medical staff for a number of years. ***Assurances: Recruit to vacant posts and Develop Nurse injectors for medical retina.***	Not applicable	**20 =**	**14/1/19** *(30/6/17)*	07/01/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1082 (855)	Radiology **S**	22	The Trust is the only one of 150 Trusts surveyed which has no digital x-ray rooms. The CR equipment, which translates x-rays into digital images so they can be uploaded into PACS, is now showing signs of imminent breakdown beyond repair. Multiple (5x) X-ray rooms cross site need updating (plus 2 fluoroscopy rooms). *Controls: regular planned maintenance. Contingency plans in event of failure* ***Assurance: Plan to seek alternative funding sources for high risk equipment in line with financial strategy.***	£2,520k (including Enabling Works)	**20 =**	**13/03/18** *(4/4/16)*	17/02/20
33	Estates – Medical Engineering Services **S**	23	Lack of capital for medical equipment 'rolling' programme. *Controls: Maintenance programmes. Small contingency to replace highest priority devices. MES uses an Equipment Replacement Priority Index.* ***Assurances: Work underway to link the replacement of Priority 1 equipment with the available charitable funds.***	c. £1.5m for Priority 1 replacements	**20 =**	**01/03/16** *(23/10/08)*	04/03/20
1105	Medicine **S**	24	Cardiac Catheter Lab needs replacement: The lab has regular periods of downtime which require repair. *Controls: Continued manufacturer support. Contract adjusted to match the requirements of an end of life piece of equipment. QA tests undertaken to monitor the systems. Email notification for risk monitoring.* ***Assurance: Official Tender for Cath Lab completed. Cath lab funding was authorised Jun-19, subject to operational priorities (location of Vanguard Unit)***	£1,000k	**20 =**	**06/06/17** *(2/8/16)*	11/11/19
910	Medical Director **S**	22	Systems (manual and electronic) do not facilitate management of significant patient test results *Controls: each Centre has their own method of making sure reports are read and actioned. This is not standardised nor is it monitored.* ***Assurances: Awaiting decision and procurement of EPR. Option appraisal for EPR submitted to Execs and business case being developed***	£18,000k over 10 years	**20 =**	**02/12/14** *(8/09/14)*	30/12/19
1548	Women and Children's **Q**	25	Risk to the Services and Trust reputation - Independent Maternity Review (IMR) *Controls:* • *Regular staff engagement & communication* • *Proactive and reactive communication plan* • *Positive communication of what has been done well* ***Assurance: Acknowledgement where there has been failure. Learning review of historical cases. Openness and honesty with staff and the public***	Not applicable	**20 =**	**12/03/19** (19/2/19)	19/02/20
1691	Cancer Services **Q**	26	Implementation of Remote Monitoring Somerset Cancer Register system *Controls: No controls in place* ***Assurance: Monthly compliance checking by CCG. Accountability framework in place***	Funding in place	**20 =**	**12/11/19** (not stated)	10/02/20
1325	Surgery **P**	27=	Automatic Endoscope Reprocessor in PRH Endoscopy at end of life impacting on RTT, patient flow, & cancer targets. *Control: maintenance and repair; transporting scopes to RSH for decontamination.* ***Assurances: Review costings and draft plan for replacement but part of wider issue with sustainability of services.***	tbc	**20 =**	**12/6/18** *(01/01/18)*	06/03/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1452	Surgery **P**	27=	Non-compliance with national decontamination standards as measured by JAG is putting risk to our JAG accreditation *Control: Decontamination processes in place in line with Decontamination policy and associated SOPs* ***Assurances: Group being established to determine how to meet best practice guidance***	tbc	**20 =**	**15/10/19** *(31/3/18)*	03/02/20

Risks rated 16							
Risk Ref	**Centre & Tier 2 Committee**	**Priority**	**Risk and update**	**Capital Action Cost**	**Score**	**Date entered on ORR** *(date identified)*	Date reviewed
853	Radiology **P**	2	RSH Vascular Catheter laboratory service is beyond end of life. The server which runs the system cannot be updated and runs on outdated software which causes the system to 'crash'. Datix reports submitted indicate regular problems with system fails *Control: no effective controls.* ***Assurances: Premium (fast response 4 hrs on site) service contract option supports this equipment***	£1,000k	**16 =**	**13/03/18** *(28/2/14)*	17/02/20
1463 881	Emergency Assessment **W**	3	Insufficient consultant capacity in Acute Medicine with increased numbers of patients, and ambulatory care not supported by defined posts. *Control: SDEC working group set up with dedicated support from ECIST* ***Assurances: recruitment of Locum and substantive specialty Doctors ongoing now funding source confirmed.***	Not applicable	**16 =**	**10/07/18** **(***3/7/14)*	09/01/20
1463	Emergency Assessment **Q**	5=	Delays in coding of A&E cards by Doctors *Control: SOP completed and circulated with Consultant sign off for completion of clinical admin.* ***Assurances: Medical Director overseeing compliance.***	Not applicable	**16 =**	**14/1/19** *(2/10/15)*	09/01/20
1034	MSK **Q**	5=	Trauma Operating time *Control: Additional temporary trauma lists and weekend lists in place* ***Assurances: Part of Trustwide recruitment drive***	Not applicable	**16 =**	**14/1/19** *(2/10/15)*	06/03/20
984	Therapies **Q**	5=	Therapy Care Group inability to meet national clinical quality standards, guidelines and service specifications Serious concerns following a review by the Midlands Critical Care and Trauma Network. One of these relates to the rehabilitation of trauma patients by all 4 therapy professions due to the lack of a dedicated trauma rehab service *Controls:7-day working where funding allows* ***Assurance: Development of combined Stroke business case following review of Stroke service. Trauma: improved performance following clarity of national definitions of rehab prescription***	Not applicable	**16 =**	**21/01/19** *(5/5/15)*	03/03/20
1699	Pathology **Q**	5=	Inadequate Governance of Point of Care Testing within SaTH *Control: Temporary Governance Lead in post* ***Assurances: Funding for the individual currently undertaking the role of improving governance arrangements***	tbc	**16 =**	**12/11/19** *01/11/12*	02/03/20
1439	Hospital Trans Programme **S**	9	Inability to adopt clinical model and realise workforce benefit ***Controls/Assurance: Progress on essential enablers to be managed by HTP Steering Group and escalated to Sustainability Committee.***	Not applicable	**16 =**	**14/02/18**	02/02/20
1571	Unscheduled Care **W**		Registered Nurse Vacancies within USC medicine and lack of agency cover leading to inability to deliver quality care to meet required patient nurse ratio in line with Safe Care Nursing information. Delivery of Quality care in all ward areas *Controls No controls identified* ***Assurances: Daily staffing plans developed by Matrons to ensure one substantive staff working in each ward area.***	Not applicable	**16 =**	**9/7/19** *(15/4/19)*	08/11/19

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1716	Director of Nursing and Quality **Q**	10=	Effective Systems for Mental Health Assessment are not completed in line with National Guidance *Controls: Staff training/awareness, SOP, escalation plan agreed with commissioners, RCA review, Serious Incident Review Group etc* ***Assurances: s31 action plan in place***	Not applicable	**16 =**	**17/12/19** (16/12/19)	03/03/20
1426	Medical Director **Q**	10=	Effective Treatment of sepsis not embedded throughout Trust *Controls: Sepsis nurse appointed and in post. Sepsis champions on wards led by Emma Salvoni* ***Assurance: Sepsis Six Bundle, elearning package and Screening tool all in place. Shared learning events held.***	Not applicable	**16 =**	**11/09/18** *(25/6/18)*	08/02/20
1644	Hospital Trans Programme **S**	13	Patients with acute Ophthalmology problems presenting to PRH ED *Control: PRH take being redirected to RSH. Case for slit lamp to CPG* ***Assurances: Alternative equipment (ophthalmoscope) being utilised assess patient***	c.£50k	**16 =**	**12/06/18** *(01/01/18)*	09/03/20
1438	Hospital Trans Programme **S**	14	Change in Trust financial position since 2015/16 business case approval impacting on overall affordability of the programme. If the programme is now unaffordable this may have an impact within the consultation *Controls: Revision of SOC to include impact of financial position.* ***Assurances: Financial assumptions to be re-examined as part of the final Strategic Outline Case. Workforce 5 year plan to be confirmed by Care Groups.***	Not applicable	**16 =**	**13/11/17**	02/03/20
1597	Decontaminati -on Service **W**	15=	Gaps within the Decontamination Service structure regarding all levels of Engineering Support and a reduced level of Authorised Person plus equipment issues are all potentially impacting on JAG accreditation. *Controls: Dedicated Contract with external Manufacturer providing service and breakdown cover.* ***Assurances: 6 month plan in place to maintain JAG accreditation***	Not applicable	**16 =**	**21/6/18**	12/03/20
1419	Ophthalm -ology **W**	15=	Paediatric Ophthalmology Service. At present the Trust only has one Consultant Paediatric Specialist. If they are unable to work this could put patients at risk if they do not have the treatment that they require and could result in delays in care potential harm to patients. *Controls: On going management of any absences and carry out initiative clinics where consultant is available..* ***Assurances: Currently limited - undertaking workforce review to ascertain and develop a succession/contingency plan***	Not applicable	**16 =**	**28/6/18**	3/5/19
1659	Surgery **W**	15=	Surgical / emergency on call / PWTR *Controls: No controls identified* ***Assurances: SBAR to be presented at execs on 15.1.2020 to gain support to go to agency / NHS locum urgently in view of risk to patient safety/ staff working 33 hours continuously***	Not applicable	**16** *Inh't score No Res'l Score* **=**	**27/9/19** *(27/9/19)*	**14/01/20**
898	Emergency Assessment **W**	15=	Impact on ED following paediatric reconfiguration. Following the transfer of paediatric services to PRH there is no on-call consultant available to attend ED for approx 30 minutes leaving a limited number of staff appropriately paediatric trained. *Controls: Training ongoing and daily review of staff cover* ***Assurances: Currently limited - more locum doctors with majority not EPLS or APLS trained***	Not applicable	**16 =**	**1/5/14** *(5/5/14)*	15/12/19
1424	Emergency Assessment **S**	15=	Backlog of ED patient record scanning. Significant delay in scanning of ED clinical documentation due to multiple systems that are not paperless. This could impact on patient care if the	tbc	**16 =**	**18/6/19** *15/10/19*	06/03/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
			information is not available at the time needed, i.e. re-attendance, completion of complaints/legal services queries. It was noted that Medway might resolve this issue in future. *Controls. Limited* ***Assurances: Overarching admin action plan awaiting approval***				
1585	Emergency Assessment **S**	15=	Acute Medical Assessment (AMA) Care Unit's remaining on Trust capacity's Escalation Policy Currently the AMA Care Units on each site are included in the hospital escalation bed base, meaning that at times of high escalation, patients are bedded into the bays. Due to capacity pressures the AMAs are frequently escalated into. *Controls. Removal of the AMAs from the Bedded Escalation Capacity Policy* ***Assurances: Acute medical footprint under review to reduce the impact of bedding down***	tbc	**16 =**	**24/4/19** *15/10/19*	15/12/19
1634	Emergency Assessment **S**	15=	Insufficient trollies in ED and AMU at both sites for patient demand. There are current insufficient trolleys to cope with demand in this area, necessitating DSU trollies to be regularly 'borrowed'. A case for funding is to be presented to Capital Planning Group in November 2019 *Controls. Borrowing trollies from DSU* ***Assurances: Management team progressing business case to address shortfall***	tbc	**16 =**	**10/9/19** *15/10/19*	09/03/20
532	Pathology **S**	15=	Amended Reports not Updating on Review. A solution to replace the server and upgrade the software is urgently required. *Controls Safeguards in place eg Microbiology follow SOP (SHADM11) which describes the process for management of revised reports.* ***Assurances: Plan to replace Review server and upgrade Review Software***	tbc	**16 =**	**11/5/19** *(1/7/09)*	03/03/20
1646	Anaesthetics , Theatres & Critical Care **S**	15=	Outdated and Insufficient number of Urology Telescopes and Accessories H The Scheduled Care management team is progressing a business case for capital investment in new Urology equipment. *Controls Fast track sets to CSSD* ***Assurances: Plan cases to mitigate equipment concerns as best as possible utilising 6 4 2 process.***	tbc	**16 =**	**25/9/19** *15/10/19*	28/01/20
1647	Emergency Assessment **S**	15=	Ageing Mammography Equipment Leading to increasing unreliability and clinical downtime. *Controls Approach has been made for any national funding.* ***Assurances: Replacement programme paper to be presented at CPG for proposed replacement.***	tbc	**16 =**	**12/11/19** *26/9/19*	10/02/20
1635	Anaesthetics , Theatres & Critical Care **S**	15=	Medication access on Critical Care, RSH and PRH Medicines Security is at risk as current processes for Critical Care in regards to the number of keys per department is not in line with local Medicine Code Policy, whilst the provision of provide safe care in this environment is often contingent upon complex nursing with medical and pharmaceutical care simultaneously. *Controls Process for Management of Keys in Place at*	tbc	**16 =**	**23/7/19** *15/10/19*	04/02/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
			handover of shifts. ***Assurances: Staff have access to keys through electronic trakka box which access is audited on a monthly basis***				
1183	IT **S**	15=	Insufficient and out dated digital data storage with risk of failure of storage units and insufficient capacity supporting growth in the Trust's digital systems and archive of data. Trust is in bottom part of lower quartile for IT spending in Model Hospital data. Storage units now old technology. *Controls: Limited. Some items have a limited warranty. Some additional storage purchased. IT identifying and engineering free space across the estate but this is becoming increasingly difficult to find* ***Assurances: Plan to seek alternative funding sources for high risk equipment in line with financial strategy. Continued strategic use of Managed Service Contracts***	£500-700k to replace whole system c.£2m of unfunded Priority 1 Schemes (including storage	**16 =**	**01/08/17** *(26/3/17)*	03/02/20
1508	Theatres, Anaesthetics & Critical Care **W**	27	Reduced Level of Engineering support due to Sickness and Staffing Levels resulting in reduced capacity at CSSD/ability to meet operational requirement impacting upon theatre capacity. *Controls: Two part time engineers available for 30 hours per week in normal working hours but not currently out of hours. Due to specialist nature of the correct skills and abilities it is highly unlikely for further control measures to be achieved* ***Assurances: Estates department to review recruitment processes to enable the appropriately qualified Engineers to be available on-site.***	Not applicable	**16 =**	**18/12/18** 7/11/18	20/02/20
1401	Pharmacy **Q**	28	The Radiopharmacy computer program was written in-house more than thirty years ago with no official support. *Controls: In event of a system crash, labels have to be hand written and calculations done manually* ***Assurances: Replace current system with an in-house built programme - part built by MP but now needs IT support to complete. Support required with structuring database and connections to SEMA***	Unknown	**16 =**	**11/6/18**	27/11/19
55	Workforce **W**	29	Attendance at statutory and mandatory training *Controls: SSU compliance part of annual appraisal process. Care Group targets and reporting* ***Assurances: Target of 90% agreed by Workforce Committee with new way of monitoring which will allow more robust understanding of where gaps are and allowed targeted approach.***	Not applicable	**16 =**	**16/09/14** *(16/11/08)*	26/09/19
1329	Pharmacy **S**	30	Trust is non-compliant with national requirements for Electronic Prescribing and Medicine Administration (EPMA) system *Controls: no controls possible* ***Update: currently exploring options for financing a solution with procurement***	£1,500k over 2 years	**16 =**	**13/02/18** *(22/1/18)*	27/11/19
265	Medicine **P**	31=	Lack of piped oxygen and suction on renal ward at RSH which impacts on dialysis capacity as ward patients cannot be dialysed on ward *Control: portable units available in emergency* ***Assurance: Capital bid ongoing***	tbc	**16 =**	**11/9/18** *(3/1/11)*	18/02/20
1747	Anaesthetics , Theatres & Critical Care **S**	31=	Contaminated Fluid Waste Management *Control: None identified* ***Assurances: YD to prepare paper for CPG. To recommend Neptune Waste Management streamlines the management of suctioned surgical waste and has some cost benefits to SaTH***	tbc	**16 ↑**	**10/3/20** *(1/1/20)*	24/02/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
1090	Trustwide **Q**	32	Lack of active monitoring system for Trust compliance with H&S legislation ***Action: Previous plan to include as part of intranet redevelopment on hold. Paper put forward for IT support for option appraisal***	£35k	**16 =**	07/03/18 *(25/4/17)*	02/01/20

Risks Rated 15							
Risk Ref	**Centre & Tier 2 Committee**	**Priority**	**Risk and update**	**Capital Action Cost**	**Score**	**Date entered on ORR** *(date identified)*	Date reviewed
816	Radiology **W**	1	Lack of Interventional Radiologists leading to no out of hour's vascular interventional Radiology service. *Controls: no controls in place* ***Assurances**: **Post offered and accepted by interventional Radiologists oversees (pending VISA)***	Not applicable	**15 =**	**26/11/13** *(3/2/13)*	17/02/20
1485	IT **P**	2=	Server licences expiry Failure to upgrade leaves these systems highly vulnerable to a cyber-attack. This could take systems out completely, take significant time to recover services and would ultimately have a significant impact. *Controls: Semahelix testing has already started. £125k has been allocated to the SQL licences.* ***Assurance: Project in progress, >50% of servers now upgraded.***	TBC	**15 =**	**14/1/19** *(2/1/18)*	03/02/20
1503	IT **P**	2=	Windows 10 Migration Windows 7 licences expire in January 2020, after which is not supported, leaving any devices and systems vulnerable to cyber-attacks. *Controls: Migration commenced using automated tool.and audit to identify obsolete equipment.* ***Assurances: over 200 devices on W10 - extra staff recruited to help with project. Significant rollout in train.***	£400k	**15 =**	**13/11/18** *(1/10/18)*	03/02/20
1650	Radiology **S**	4=	Potential Security Breach Due to a Lack of a Segregated IT Network for Radiology/Imaging Equipment *Controls: Specialist IT support to ensure radiology equipment is currently on the clinical network* ***Assurance: Business continuity plans in place for imaging modalities to function in the event of network failure***	tbc	**15 =**	**12/11/19** *(26/9/19)*	17/02/20
1685	Medicine **Q**		Passed Max Waits – Renal. *Controls: 2 WTE have been loaned from the Booking team to support validation of Past Max Waits* ***Assurance: Care Group management team seeking approval for additional substantive posts following inability to recruit to fixed term posts.***	tbc	**15 ↑**	**10/3/20** *(12/11/19)*	31/01/20
1123	Estates **S**	4=	Regulatory risk relating to capital strategy for fire safety *Controls*: *PPM on fire alarms, fire safety training, fire doors, evacuation procedures for ward block* ***Assurance: Recurrent funding included in 2019/20 Capital Programme includes £300k***	£300k pa	**15 =**	**02/09/16** *(7/9/13)*	02/03/20
1209	Pathology **Q**	6=	Capacity in Phlebotomy. Several GP practices have stopped providing phlebotomy without giving SaTH notice of doing so. *Controls: All phlebotomy clinics are walk -in services and therefore difficult to control* ***Assurances: Work with others to identify alternative space for phlebotomy, either in the community or within SaTH**.*	Not applicable	**15 =**	**18/12/18** (1/8/17)	29/02/20
1658	Pathology **Q**	6=	Cellular Pathology Tracking System modernisation An electronic tracking system would prevent mislabelling errors and the management team is working to procure a permanent solution *Controls: Manual processes in place* ***Assurance: Tracking System business case is being progressed by management team to identify***	tbc	**15 =**	**1/10/9** 15/10//19	02/03/20

Risk Ref	Centre & Tier 2 Committee	Priority	Risk and update	Capital Action Cost	Score	Date entered on ORR *(date identified)*	Date reviewed
			funding				
974	Oncology and Haematology **P**	9	Capacity for outpatient appointments in oncology not meeting demand *Controls: Waiting list initiatives; Telephone follow up consultations* ***Assurances Business for additional Consultant resource being progressed by Management Team.***	Not applicable	**15 =**	**13/03/18** *(1/5/15)*	05/02/20
1235	Trust wide **Q**	10	Use of NIV Initiation Room on Ward 22RE for escalation *Controls: Hospital Full protocol; local risk assessments* ***Assurances: increased focus on achieving recommended % occupancy with emphasis on improving discharge.***	Not applicable	**15 =**	**03/10/17** *(30/6/17)*	31/10/19
1355	Facilities **P**	11	Oven failure in kitchen area at PRH – which could result in ability to provide hot meals for staff and visitors with subsequent loss of income (£227k pa) *Controls: use of alternative, but increases risk of failure of this oven* ***Assurances: Facilities Management team progressing funding options to replace oven***	£11k	**15 =**	**10/4/18** (20/3/18)	02/03/20
1208	Pathology **Q**	12	Failure to meet national standards for histopathological reporting of lymphomas / Risk of incorrect diagnosis. Following the retirement of our existing Histopathologist none of our existing Histopathologists have the required Haematolopathology expertise, there is a national shortage of Histopathologists and we've been unable to recruit to the vacant post. *Controls: Cases to be sent from SaTH to UHB commencing w/b Monday 24th December 2018* ***Assurance: A service level agreement will need to be put in place between SaTH and MIRHO Investigation of alternative diagnostic pathways which ensures compliance with peer review measures.***	*Unknown*	**15 =**	**18/12/18** (4/5/17)	02/03/20
1567	Women and Children's **Q**	13	Risk to Patient Confidentiality and Continuity of Care - Medical Records off-site for Independent Maternity Review (IMR) *Controls: ad hoc cover* ***Assurances:*** ***• Patient safety incidents – IG*** ***• Complaints*** ***• Audit*** ***• Peer reviews***	Not applicable	**15 =**	**13/8/19** (27/3/19)	06/02/20
1595	Women and Children's **Q**	14	Impact on operational delivery of maternity services at RSH MLU due to adjustments to meet building safety regulations within the space *Controls: Plan in place for safe relocation of services with associated Comms.* ***Assurances: Low risk inpatient services are available at Wrekin MLU.***	Not applicable	**15 =**	**13/8/19** (17/5/19)	06/02/20
1649	Radiology **Q**	15	Management of Governance within Radiology *Controls: The management team are prioritising legislative compliance standards, particularly IR(ME)R so as not to receive any enforcement action* ***Assurances: Role of Assurance Lead Superintendant Radiographer developed***	Not applicable	**15 =**	**12/11/19** (26/9/19)	17/02/20

Appendix A: In process of completion

Risks Rated 20 - in process of completion							
1582	Finance Director **Q**	-	Complexity of Upgrade of SemaHelix to v7.10 compounded by lack of capability and capacity in Informatics ***Closing comments: Director of Finance explained at Sustainability Committee that a decision had been taken not to implement the SemaHelix upgrade in light of move to EPR and to accept the risks that this presented.***	tbc	**Closed**	-	-
1551	Patient Access and OPD **Q**	-	Inability to provide MRI scanning for ITU patients. No equipment to safely scan level 2 or level 3 critical care patients. MRI rebuild now has infrastructure to allow this but still no equipment ***Closing comments: Discussed at TACC governance. Items received on site. Risk closed***	tbc	**Closed**	-	-
1601	Renal **W**	-	Insufficient capacity within Renal Home Therapies Service The Unscheduled Care Group has identified that insufficient capacity within Peritoneal Dialysis and Low Clearance service means care provided is limited. *Controls: The Care Group has sought additional funding which has been verbally agreed with local CCGs* ***Assurances: Approval to appoint all post given. Risk score will be reviewed once posts recruited to.***	Not applicable	**20**	-	-
820	Medicine **S**	-	Renal Dialysis Station Replacement. Following a further 3 machines being condemned during 19/20 financial year it has been advised that it is unlikely a replacement machine will be able to be sourced through the contingency funds. As a result our mitigation of this risk is reduced and the risk score has been increased. *Controls: Machines in use are rotated to facilitate repair* ***Assurances: Rolling programme to replace machines within capital constraint All machine stations referred here are now funded and about to be replaced. Any further known dialysis machine replacement needs are being worked up in a SaTH overall replacement plan currently.***	tbc	**20**	-	-
1549	Women and Children's **W**	-	Absence of Head of Midwifery ***Controls/Assurance: Director level appointment in progress, interim support in place.***	Not applicable	**8**	-	-
1181	Outpatients **S**	-	There is a shortage of space in records at all sites to house the current number of Patient records on suitable shelving. ***Closing comments: The Trust Board has now approved funding for off-site storage solution. This risk still remains live until the solution is realised.***	Unknown	**Closed**	-	-
1029	Radiology **Q**	-	Backlog of radiology reporting leading to quality and safety risks, & financial risks caused by national shortage of radiologists and increase in number of examinations. Impacts on cancer waits, delayed diagnoses, increasing complaints *Controls: Outsourced reporting, WLIs, HotDoc system* ***Assurance: SBAR paper submitted to execs. Continued recruitment attempts including from oversees. Consultant Radiographer now in post to help with plain film workload. Development of Consultant Radiographers, and Advanced Practitioners***	Not applicable	**12**	-	-

Risks Rated 20 - in process of completion							
1045	Radiology **S**	-	PRH CT scanner is becoming increasingly unreliable with significant unplanned downtime experienced over the past 6 months impacting on patient treatment, patient flow, staffing, and the ambulance service. *Controls: regular planned maintenance. Contingency plans in event of failure* ***Assurances: Installation of new CT scanner ready for go live (August approx.)***	Range - £566k-£1,041k (including Enabling Works)	**20**	-	-
1528	Ophthalmology **Q**	-	Air conditioning unit to cover Area C in Opthalmology Area A and B in the Eye Department reach consistently high temperatures during the summer months. *Controls: Dyson fans have been put in place, along with water and regular breaks for staff.* ***Assurances: funding obtained for air conditioning unit for Area C***	All actions implemented	**12**	-	-
1484	IT **P**	-	IT cyber security All NHS Trusts are expected to monitor and control IT Security Risks. To ensure compliance and higher levels of security then SaTH needs to have a dedicated IT Security Manager. We do not currently have this. This has also been flagged by external auditors KPMG.	Funding for additional posts secured	**12**	-	-
688	Pathology **Q**	-	Technology used to determine microbial sensitivity is outdated and not fit for purpose. We are the only 1 of 50 previous PHE laboratories to still use the old technology ***Closing comments: Microbiology department is now using broth dilution MIC system as opposed to disc diffusion and is following EUCAST guidelines***	Solution in process of being implemented	**Closed**	-	-
1441	MSK **Q**	-	Mortality rate at PRH for # NOF National outlier for the mortality rate of hip fractures patients at PRH - source National Hip Fracture Database Unknown cause of mortality rates. ***Closing comments: data review of patients from the NHFD database in line with the stated national average***	All actions successfully implemented	**Closed**	-	-
744	MSK **Q**	-	T&O adversely affected by patient flow failures Controls: Trust considering ring fenced orthopaedic beds. ***Closing comments: protected Orthopaedic Elective beds. Trauma patients and medical outliers are still using ward 4 but this risk is covered by risk 1480***	Protected Ortho Elective beds	**Closed**	-	-

Risks Rated 16 - in process of completion-							
1382	Anaesthetics and Critical care **P**	-	The recovery area for Theatres 10 and 11 at RSH should have a minimum of 10-15 air changes per hour according to HTM guidance for recovery areas. ***Closing comments: Theatres 10/11 handed to unscheduled care. Airlfow issues no longer relevant.***	Unknown	**Closed**	--	-
1565	Patient Access and OPD **S**	-	Fire Risk – Copthorne Building – risk of enforcement action by SBC and/or SFRS ***Closing comments: The Trust Board has now approved funding for off-site storage solution. This risk still remains live until the solution is realised***	Unknown	**Closed**	-	-
1216	Medicine **W**	-	Dermatology: clinical risk due to single consultant. Unable to recruit additional consultant and service provided by uncapped agency doctors. *Controls: Sub-contracting activity. Locum in post* ***Update: Care Group tendering for additional capacity Issue covered in 'Services in Spotlight' paper to Board.***	Not applicable	**6**	-	-
1521	Pathology **Q**	-	Insufficient body storage capacity in Mortuary at PRH Failure to store bodies in appropriate conditions in the *Controls: 2nd Nutwell unit procured to provide some extra capacity to mitigate winter pressures* ***Assurances: Nutwell unit now in use at PRH.***	£11,000	**12**	-	-
1274	Head and Neck **Q**	-	Following the ward move from Ward 8 to 17 the new ward does not have a treatment room for patients. This has resulted in patients having to be treated in a bed space, which has been closed to inpatients. ***Closing comments: treatment now completed and ready for use for Head & Neck patients***	Unknown	**Closed**	-	-
1348	Women & Children **P**	-	Colposcopy clinic facilities at RSH – poor patient environment. *Controls: Estate improvements and prioritisation form part of capital planning process and space utilisation group* ***Assurances: incidents relating to patient experience of environment to be escalated to care group risk group.***	£21k	**9**	-	-
493	Emergency Planning **Q**	-	Emergency decontamination tent for casualties of chemical incident. The Trust is required to have a functional decontamination tent in line with the Civil Contingency Act. The current inflatable unit has multiple failures and cannot be repaired. *Controls: Limited - a business case is being developed by management team/EPO to replace tent.* ***Assurances: Estates training complete and several mock erection opportunities for E training undertaken.***	£7k	**12**	-	-
1413	Renal Dialysis capacity **Q**	-	Renal Dialysis Capacity All of the in centre dialysis units are oversubscribed and there are currently an extra 7 patients being dialysed on Sundays and out of hours. Over the Christmas period and January 19, there is a major risk to patients as there is no more space for patients even with the contingencies in place. Renal consultants will be approaching HDU to ask if they can help out if more patients require dialysis until the twilight shift opens on 27th January 19 at PRH. This risk score has been increased due to the immediate risk to patient and will remain at this level be until the twilight shift opens at the end of January. *Controls: Additional capacity at Ludlow (now providing 6 day/week service not 3) and PRH and transfers to UHNM and Tipton where appropriate*	Not applicable	**20**	-	-

Risks Rated 16 - in process of completion-							
			Assurances: Business case being progressed by management team for managed service option.				
1653	Director of Corporate Governance **W**	-	Expired Hospital Identity Badges. Imminent expiry of majority of ID badges leading to resource issue within Estates Dept. and associated costs. A plan in place to manage situation. ***Closing comments: Required actions complete.***	c.£30k	**Closed**	-	-
1190	Women & Children's **W**	-	Reduction in numbers of Advanced Neonatal Nurse Practitioners (ANNP) due to retirement and maternity leave; and national shortages of trained staff. ***Closing comments: Advert out for full time/part time vacancies Risk to be removed – LA to review and confirm that risk can remain closed***	Not applicable	**Closed**	-	-
1362	Medicine **P**	-	Polysonographer machines are approaching the end of their life and require replacement. The department now only have two working machines in situ. with a two further machines needing repair. The manufacturers have now stated that the machines are beyond economical repair. ***Closing comments; Machines in situ.***	Not applicable	**Closed**	-	-
1502	Corporate Nursing **Q**	-	HPV machine The Trust needs a further machine to be able to meet the demand across both sites. ***Closing comments: Second deprox machine purchased and on site at RSH leaving original machine at PRH***	£36,000	**Closed**	-	-
1417	Ophthalmology **P**	-	The Ophthalmology Microscope in Theatre 8, which was used to carry out intra ocular surgery, is no longer fit for use. ***Closing statement: Microscope purchased and installed***	£80,000	**Closed**	-	-
1002	Pathology **P**	-	The autoclaves are over 13 years old, with a life expectancy of approximately 15 years. Replacement parts are being cannibalised from other old machines to keep them functional. *Controls: Preventative maintenance is in place via the Estates Dept and supported by an external company.* ***Assurances : On-going monitoring to ensure control measures remain effective***	£150,000	**16**	-	-
1449	Anaesthetics and Critical care **P**	-	Obsolete critical independent monitoring systems for washers and autoclaves in Sterile Services. System increasingly prone to failure which would result in loss of capacity and impact on surgical capacity. ***Closing comments: New IMS installed new software and hardware replaced with latest versions.***	£14,000	**Closed**	-	-
1394	MSK **Q**	-	Capacity issues in # clinic following closure of ED clinic. This has led to an increased demand in clinic which is impacting on times to theatre, and waiting times for review. ***Closing comments: Implementation of ESP clinics to divert appropriate soft tissue injuries from consultant clinics***	All actions implemented	**Closed**	-	-
1179	Corporate Nursing **W**	-	Lack of Nutritional Team. There are a wide range of patients across the Trust that are receiving Nutritional support via enteral tubes or intravenous lines. ***Closing Comments: Business case approved and funded. Nutritional team post recruited to.***	Not applicable	**Closed**	-	-

Risks Rated 16 - in process of completion-							
1225	Corporate **Q**	-	Care of patients with tracheostomies Trust-wide does not meet national guidance *Control: Critical care outreach provide some support to wards* ***Closing Comments: Funding for practitioner post agreed and recruitment in progress***	Not applicable	**Closed**	-	-
tbc	Corporate **W**		ID Badges - During the remainder of 2019/20, the valid date on the majority of staff photographic identity badges will expire. For many their photographic identity badge expiry date will be the same for their door access swipe card. Systems and resources have been allocated to ensure the Estates team can handle the demand and issue replacements in a timely manner.	Resource in place	**16**	-	-

Risks Rated 15 - in process of completion							
1442	MSK **Q**	-	Outlier conservatively managed hip fractures at PRH Outlier nationally on volume of patients being treated conservatively as per National Hip Fracture Database. The cause for this is unknown. Further work is being carried out to ascertain the cause. ***Closing Comments: Management team asserts that current 30 day mortality rate is consistently in line with the National 30 day mortality rate.***	All actions implemented	**Closed**	-	-
1331	Medicine **W**	-	Diabetes Specialist Nurses It is thought that the department are short of 1.9 wte. Nationally the levels of diabetes are known to be rising and this problem is only likely to get worse as the demand continues to increase. *Controls: Cancelling scheduled clinics to ensure that in patients are reviewed. Current staff working over time and extra shifts to try and see patients* ***Assurances: All positions now filled. Nurses are working to gain the required skills***	Not applicable	**15**	-	-