The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 March 2024

Agenda item		051/24			
Report Title		Risk Management Report Quarter 3 2023/24			
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			
Executive summary:		1. The Board's attention is drawn to the 'Summary Position', 'Progress from June 2023 and Next Steps'; and 'Issues for the Board's Consideration' sections. 2. If divisions do not regularly monitor their risk registers, there is a risk that the organisation may not be achieving its strategic goals. 3. We are currently: (a) attending as many of the divisions' governance meetings and risk-specific meetings as possible; and (b) delivering Risk Management training at RSH and PRH. Over 70 colleagues have been trained since September 2023.			
Recommendations for the Committee:		The Board is asked to: **Note** this new format report, 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 October, November, December 2023 and January 2024 with severity breakdown. Appendix 2: Summary of the Corporate Risk Position at 08 February 2024. Appendix 3: Corporate Risk Register at 08 February 2024.			

1.0 Introduction:

1.1 Historic Position:

Historically, the Senior Leadership Committee (Operational) received a monthly Risk Management report detailing the current position for all risks. The monthly report was also distributed to >100 staff. However, a quarterly report will now be produced for both the Board and the Audit & Risk Assurance Committee (ARAC) respectively. This is the first such report.

An annual risk management report will be produced for ARAC and Board each year up to the end of March to align with the Trust's year end. For 2023/24, the annual Risk Management report will be produced up to 31 March 2024, albeit with nine months of data to reflect the accuracy of data extracted from Datix.

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 meetings. New extreme risks are also presented at the Risk Management Committee (RMC), where they are made active.

1.2 Progress Since June 2023 (arrival of new Head of Risk Management):

Since June 2023, James Webb (Head of Risk Management) and Holly Burrows (Risk Officer) have undertaken the following measures to improve risk management processes at SaTH:

- The Risk Management Team have attended as many meetings as possible to introduce themselves to teams Trust-wide
- The Trust's audit recommendations tracker has been reviewed and discussed with the MIAA team. Seven of the eight audit recommendations have been closed, with one remaining, which has been descoped until strategic objectives are reviewed and risk appetite refreshed against the renewed objectives
- The Risk Management face-to-face and virtual training programme was piloted on 20 September 2023 and has been rolled out (over 70 members of staff have received this training since September 2023)
- Risk Management 'E-learning' training was designed in conjunction with the Learning Management System (LMS) Team and went live December 2023
- James Webb and Holly Burrows have completed a BTEC in Education and Training to help train SaTH staff in Risk Management
- The Risk Management Team are now part of the 'Strive Towards Excellence Programme' (STEP) where Risk Management is covered as part of Day 3's syllabus. This was delivered in June and November 2023 and will be delivered throughout 2024
- The Risk Management Committee's (RMC) Terms of Reference have been reviewed and discussed, and it has recently been agreed that one of the Medical Director, Director of Nursing or Chief Operating Officer will attend each meeting – the TOR will be updated to reflect this position before being approved
- The operational monthly Risk Management report has been revised so that metrics and proposed key performance indicators (KPI's) can be further discussed by the RMC and the report's structure and content will continue to be reviewed. This will help formulate an annual report ending March 2024 when risk management activity can be tracked on a monthly, quarterly and ultimately annual basis

- The Risk Management Policy (and Process document), Risk Management Strategy and Risk Assessment Tool have all been reviewed and discussed by the RMC – these are due to be taken to ARAC in the near future for review
- The Risk Management module on Datix has been regularly nuanced with experienced Datix software colleagues in order to make the risk management process even more accurate but user friendly
- The Risk Management Team have attended various Hospital Transformation Programme (HTP) meetings so that the HTP workstream leads can be supported in their risk management activities
- The Risk Management Team have rolled out a 'Walk Around' system at PRH so that the team has a presence on site.

3.0 Summary of current Operational Risk Position:

The Risk Management team have been following up all risk activity on Datix for assurance.

In July 2023, the Risk Management team detected 110 'open' risks dated from 2009 – end of 2019 (pre-COVID – roughly 25% of the open risk register). The Risk Management team will eventually close (and refresh with a 2023 timestamp and new Datix ID) all 110 risks with the objective of determining:

1. whether the risk lead still works in SaTH or still works in the department
2. whether the variables that originally affected the initial risk need to be updated
3. whether the risk (event) has happened or if the problem is *happening*
4. whether the risk involves more areas of SaTH than originally stated
5. whether there are any separate risks that have come out of the initial risk
6. whether the risk has an action plan
7. where there is an action plan, the action(s') lead still works in SaTH or still works in the department
8. where there is an action plan, the action(s) pledged have been implemented
9. where there is an action plan, the effectiveness of the implemented action(s)
10. where there is no action plan, who needs to devise an action plan
11. whether the risk can be closed.

The table below shows the operational risk position by approval status over Quarter 3 2023/24, *including January 2024 data*, to bring the position right up to date.

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.

Trust Wide Risk Position by Approval Status	October 2023 Total	November 2023 Total	December 2023 Total	*January 2024 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)*	**406**	**406**	**408**	***410***
2. Total No. of **Newly Identified Risks** *(Default approval status once risk is populated in Datix and has not been*	**52**	**49**	**55**	***57***

reviewed by anyone other than the risk reporting officer)				
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)*	**7**	**8**	**7**	***10***
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)*	**13**	**17**	**19**	***18***
5. Total No. of **Accepted and Closed Risks** *(All stakeholders have made an informed decision to take and 'accept' the risk)*	**217**	**242**	**254**	***260***
6. Total number of **Overdue Risk Reviews** for **Open risks**	**165**	**117**	**158**	***219***

See Appendix 1 for the Divisional operational risk profile from October, November, December 2023 *and January 2024* with severity breakdown.

4.0 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). This breakdown has allowed for a thematic analysis of the risk position, as below (we will be looking at creating a target risk score that will align with the risk appetite score).

See Appendix 2 for the Summary of the Corporate Risk Position at 08 February 2024.
See Appendix 3 for the detail of the Corporate Risk Register at 08 February 2024.

5.0 Next Steps for Risk Management:

- Evening risk management training sessions will be provided for night shift workers via Microsoft Teams
- Quadrangulate: (1) feedback from the Patient Advice and Liaison Service (PALs); (2) patient safety data; and (3) clinical audit activities with the risk management strategy. Opportunities for continual improvement should also be highlighted upon quadrangulation. This is especially important considering the implementation of the Patient Safety Incident Response Framework (PSIRF)
- An anonymised survey focusing on the RMC process (frequency, length and time etc.) will be undertaken in the near future

- Undertake a follow-up anonymised Trust-wide survey to determine how staff feel about risk management across the Trust.

6.0 Longer term plans to support the change of Risk Management Culture:

- The Trust's Risk Appetite statement will be further refreshed to reflect the Trust's current risk position
- 'Risk Management' should be a standing agenda item at all divisions' Governance meetings in order to ensure risks are reviewed as per their severity (where divisions do not currently hold specific 'risk management' meetings)
- All senior staff members should encourage staff to: raise / assess risks in their areas; involve staff in the management of risk; regularly update staff on progress of the management of risks; feed-back to staff the upshot of risks upon closure; and review the efficacy of risks' action plans 6-12 months after the risks have been closed
- All senior staff members must ensure that risks' action plans are closed before the risk itself can be closed
- A large majority of SaTH staff have had no formal risk management training. This is being remedied by the onsite risk management training sessions at RSH and PRH. Four modules of separate Risk Management E-Learning have been made available on LMS since December 2023 as part of the Getting to Good strategy.

Appendices

Appendix 1 - Divisional risk profile October, November, December 2023 *and January 2024* with severity breakdown:

Open Risks by Division and Level of risk	October 2023 LOW (1-3)	November 2023 LOW (1-3)	December 2023 LOW (1-3)	*January 2024* LOW (1-3)	October 2023 MODERATE (4-6)	November 2023 MODERATE (4-6)	December 2023 MODERATE (4-6)	*January 2024 MODERATE (4-6)*	October 2023 HIGH (8-12)	November 2023 HIGH (8-12)	December 2023 HIGH (8-12)	*January 2024 HIGH (8-12)*	October 2023 EXTREME (15-25)	November 2023 EXTREME (15-25)	December 2023 EXTREME (15-25)	*January 2024 EXTREME (15-25)*	October 2023 Total	November 2023 Total	December 2023 Total	*January 2024 Total*	Difference Month on Month
Surgery, Anaesthetics and Cancer	2	4	4	*4*	12	10	9	*9*	86	90	94	*93*	33	33	31	*32*	133	137	138	*138*	⇔
Medicine and Emergency Care	1	1	1	*1*	4	5	5	*6*	60	53	55	*56*	35	33	35	*36*	100	92	96	*99*	⇑
Women and Children's	0	0	0	*0*	6	7	6	*6*	34	39	39	*38*	11	7	8	*9*	51	53	53	*53*	⇔
Clinical Support Services	0	1	1	*1*	14	13	10	*10*	24	24	28	*28*	20	19	20	*20*	58	57	59	*59*	⇔
Corporate Division (Departments)	9	9	9	*10*	29	28	26	*27*	68	72	72	*75*	17	14	13	*16*	123	123	124	*128*	⇑
Total	12	15 ⇑	15 ⇔	16 ⇑	65	63 ⇓	56 ⇓	58 ⇑	272	278 ⇑	288 ⇑	290 ⇑	116	106 ⇓	107 ⇑	113 ⇑	465	462	470	*477*	⇑

Appendix 2 – Summary of Corporate Risk Register Position at 08/02/2024

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

CORPORATE RISK REGISTER v1

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	**743, 645, 534, 363, 366, 373, 424, 480, 535, 665, 776, 38, 513, 156, 169, 612, 284, 195, 343, 464, 564, 173, 303, 304, 698, 730, 778, 825, 111, 194, 198, 242, 454, 648, 701, 702, 761, 804, 720, 662, 50, 685, 720, 813, 559, 338, 430, 347, 422, 75**
Caring	2	**Poor patient experience**	**DON /MD**	Patients may experience delays in provision of timely care, in a suitable environment	Increasing demand on services: 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	**743, 480, 534, 111, 194, 242, 648, 630, 761, 195, 612, 50, 720, 813, 347, 338, 75**

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nain		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	5	4	20	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	**105, 156, 169, 612, 633, 195, 177, 173, 305, 484, 155, 464, 804, 559**
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:	5	4	20	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	**743, 659, 373, 534, 242, 183, 628, 629, 648, 630, 725, 761, 804, 116, 195, 612, 618, 303, 306, 698, 769, 778, 50, 720,** 559, 347. 338
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	**743, 536, 665, 424, 427, 776, 480, 536, 659, 303, 38, 128, 633, 156, 231, 283, 284, 343, 346, 305, 306, 708, 618, 730, 769, 157, 61, 801, 616, 648, 628, 629, 202, 201, 220, 585, 537, 578, 725, 249, 111, 197, 198, 804, 685, 32, 38, 41, 50, 648,** 774, 789
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	3	4	12	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	520, **128, 156, 169, 757, 825, 155, 648, 761, 112, 776, 389, 535, 424, 665, 27, 813**
Safe / Responsive	7	**Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment**	**FD** (estate) **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	**371, 349, 366, 476, 645, 682, 755, 568, 633, 769, 191, 228, 241, 243, 626, 627, 728, 662, 840,** 199, 443, 422, 679, 645, 790

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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
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	499,
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, 524, 279, 276,464, 627, 630, 631, 728, 626, 701, 767, 747, 826

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