Agenda Item: 12

ID	Opened	Strategy objectives	Responsible Lead / Handler	Manager (Executive lead)	Exec / Director	Rating (initial)	Risk Level (Initial)	Risk Description	Cause	Effect	Existing Controls	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk level (Current)	Progress notes	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Date of next Review
392	02/05/2006	Patient Risk (Quality)	Cilingo, Iain	Hunter , Nichola	Finance	25	Extreme / Very High	There is a direct risk to life and safety of patients, visitors and staff of the trust due to the potential of catastrophic failure of the roof structure due to structural deficiencies.	Pre-cast concrete construction of the building is 40 years old lifespan originally designed to last 25 years. The significant structure is showing signs of deterioration. 2016 - structural cracking found within 2 walls of the area surveyed	Potential risk to service delivery and safety of patients staff and public. 2016 survey report identifies further movement.	Additional monitoring has been implemented in key areas identified as weak points. Initial Radar Survey to 3 pre-selected Roof Zones to help identify plank locations along with an initial assessment of reinforcement Further internal and external intrusive investigations are now required within the 3 designated Zones whereby sample cores and assessments can be made and conclude the structural investigation report. MLM have provided an updated safe loading capacity for Fire Brigade Access	Catastrophic (5)	Likely (4)	20	Extreme / Very High	[Kahn, Mustafa 19/11/20 12:09:16] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 15:31:40] Risk reviewed and approved by Executive Lead in November 2020. [Carlton, Emma Mrs 27/10/20 10:20:21] Risk reviewed 27.10.20 with Head of Capital and remains as scored - an update paper has been attached to this risk which was presented to the emergency planning committee on the 21st October. Week beginning 2nd Nov, Castons chartered surveyors will be on site and will commence visual and intrusive surveys of the roof and wall planks. 4 surveyors will be on site reporting to the roof project manager. Proposed Activities Over The Next Period: Agree capital funding arrangements with NHS England / Improvement. Estates team to complete visual survey inspections of exposed roof planks in accessible locations. Installation of failsafe supports to be completed in Estates, Necton & Gayton Ward areas and main kitchen. MLM and Survey Solutions to undertake update laser deflection surveys in Marham, Gayton, Elm, Windsor and Pathology/Biomedical. Review and update Staff Communication Plan in particular with respect to Ward areas. Complete design, procurement and installation of failsafe support system for ramp to first floor. Agree scope and programme of on-going roof repairs and remedial works including relocation of mechanical and electrical services to reduce roof loading (if required). Review requirement for further specialist risk advice and whether an ALARP (As Low as Reasonably Practicable) risk review is required. Agree strategy for surveys in critical patient areas, theatres, Central Delivery Suite, NICU. Agree strategy and programme for installation of modular ward areas and modular theatres	Major (4)	Rare (1)	4	Low	01/12/2020
2244	04/03/2016	Patient Risk (Quality)	McGuire, Mrs Karen	McGuire, Mrs Karen	Chief Operating Officer	12	Moderate	There is a risk that patients presenting with acute mental health needs, assessed as requiring an admission to a mental health care bed by NSFT (therefore with a decision to admit time) will remain in the emergency department for prolonged periods due to a lack of community inpatient mental health beds. This is a suboptimal environment for patients in crisis, leading to a poor patient and staff experience, with delays for these patients to access the required inpatient assessment and treatment.	National shortfall in mental health beds provision and an increase in demand Reduction in local resource with high demand Potential long waits to access community services so patients present at A&E Assessment inpatient beds for severe dementia only available in Norwich Insufficient provision of beds for young people in crisis and mother & baby beds. No MH bed management between midnight and 8am.	Poor patient experience Detained patients being unable to access the required assessment and treatment for their mental illness Trust assumes risk of care to patients outside of core commissioned services Increased risk of harm to staff and other patients. Higher risk of self-harm events from MH patient cohort whilst not in specialist facility. Trust at risk of breaching statutory and regulatory requirement including 12 h breaches from decision to admit from ED. Potential delay in assessment and treatment Negative impact on internal patient flow	Statutory process for detaining a patient provides a framework for compliance. Inpatient liaison service plus NSFT aim to work in an integrated fashion. ED staff escalate delays early in the patients journey to mitigate against the risk of 12 hour breaches. Escalation to CCG on a regular basis. Estates work undertaken in ED to reduce risk of self harm to patients presenting in mental health crisis (e.g. removal of potential ligature points) to reduce risk of patient harm. Mental health training provided to all ED staff and mental health risk assessments for paediatric and adult patients with mental health needs have been reviewed and updated to reduce risk of poor patient experience. Highly supportive visit 3/12/19 by East London Foundation trust (outstanding mental health provider) to review and advise on progress and any additional steps required.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 10/11/20 15:44:20] Update provided by the Head of Nursing: There are currently no changes in November 2020. [Kahn, Mustafa 10/11/20 15:46:58] Risk reviewed and approved by Executive Lead in November 2020. [Kahn, Mustafa 19/11/20 12:44:08] Risk reviewed at AREG in November 2020 and was approved to remain as graded.	Moderate (3)	Unlikely (2)	6	Low	01/12/2020
2483	24/07/2018	Process / Corporate Risk	Notley, Louise	FS2	Medical Director	16	High	There is a risk of reputational damage to the trust if regulatory notices from the CQC (Section 31 and Section 29A notices) are not removed or acted on effectively. This could effect the trust's ability to deliver quality care and could also effect the trust's position in the STP.	CQC Section 31 and Section 29A notices received covering various aspects of care.	Adverse publicity and poor institutional reputation may affect the trust's ability to provide high quality care. This may mean that the trust remains in Special Measures and therefore endanger the future sustainability of the trust.	Divisional structure revised to provide additional leadership and support to areas with section notices in place September 2019. October 2019: Integrated quality improvement plan (IQIP) now in place, regular performance review meetings taking place Corporate action plan to address concerns raised under section 29A and section 31 by CQC regulatory framework. Regular monitoring and updating of the section notices within the IQIP via the Conditions and Notices Oversight Group (CONG) which reports to the Evidence & Assurance Group (EAG). Strengthened governance arrangements in place with Board oversight of progress and evidence via EAG and CNOG.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:38:40] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:19:35] Risk reviewed and approved by Executive Lead in November 2020. [Notley, Louise 23/10/20 07:26:57] Risk reviewed by L Notley. Currently waiting for CQC inspection report before considering any change to risk rating. Currently reviewing Section 31 conditions to consider an application to the CQC to request the lifting of these conditions, following their recommendation during its recent inspection. Until then recommend risk remains unchanged.	Major (4)	Rare (1)	4	Low	01/12/2020

2592	16/09/2019	Patient Risk (Quality)	FS2	FS2	Medical Director	20	Extreme / Very High	There is a risk that patients may receive sub-optimal care / treatment, with failures in: - Outcomes - Safety - Experience	Inconsistent compliance with standards and policy Inappropriate skills mix / capacity Ineffective training Ineffective leadership Poor communication with patients and carers Failures in documentation and record keeping Lack of patient involvement / choice Sub-optimal pathways and poor flow through the organisation Failure to identify and manage risk effectively Very high demand for services Lack of community capacity / social care Failure to assimilate learning	Higher rates of avoidable deaths Patient harm Increasing incidence of Infection outbreaks Poor patient outcomes Poor patient satisfaction Increased number of SIs / Never Events Poor regulatory / accreditation inspection outcomes & regulatory intervention Adverse media coverage / reputational damage Poor patient flow DTOCs and people being cared for in an inappropriate environment Delayed treatment Highly pressured working environment for staff Contract breaches	•New divisional structure with greater accountability •Interim director of Patient Safety appointed and Deputy Medical Director commenced in post •IP&C Interim appointment; improvements against action plan Recent NHSI/E / CCG visit determined significant improvements now rated as amber •Mortality Lead, Medical Examiner and Medical Examiner Officer appointed. •End of Life Care Improvement Plan in place with clinical lead •Regular Performance reviews!! •New management template in place for managing serious incidents, including milestone reporting and twice weekly serious incident panels. •Integrated Quality Improvement Plan refreshed and in place supported by Quality Improvement team •IPR - performance variable. Positive on Stroke and Diagnostics. Reducing DTOCs. Divisional Director for surgery in place Emergency planning in place to mitigate risks associated with COVID-19 46 of 46 CQC conditions, should dos and must dos internally closed at Evidence Assurance Group and moved to BAU. Positive feedback from Grant Thornton audit in relation SI process and learning. There is an improving position in relation to out of date guidelines and policies. Ongoing Clinical Review programme. Additional resource in place to support End of Life patients and management of deteriorating patients. Positive feedback from unannounced CQC inspection.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:29:13] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 15:49:09] Risk reviewed and approved by Executive Lead in November 2020.	Major (4)	Rare (1)	4	Low	01/12/2020
2634	27/08/2019	Patient Risk (Quality)	Jones, Ms Sarah	Donovan, Joanne	Chief Operating Officer	15	High	There is a risk that patients will not receive timely access to cancer treatment in line with the cancer waiting time standards.	Capacity not meeting demand particularly in the diagnostic phase. Histology/Pathology results are delayed Patients are not informed of negative results in a timely manner Lack of capacity in both clinics and Theatre. Heavy reliance on Tertiary Centres	Delays may cause avoidable death or serious harm, shortened life expectancy or prolonged pain Adverse media coverage or public concern about the organisation. Inability to meet the current Cancer Trajectory/PTL Targets.	Harm Review policy implemented (breach analysis completed for patients who have breached the 62 day referral to treatment standard and harm review completed for patients exceeding 104 days). Weekly PTL and escalation meeting to DLT Recovery trajectory in place for each site. The Trust is engaged with the cancer intensive support team and has an agreed improvement plan in place. Extra monies have been received from the STP to clear the colonoscopy backlog by the end of August 2020 - extra weekend listings have been set up.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:40:17] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:14:49] Risk reviewed and approved by Executive Lead in November 2020. [Malyon, Lisa 02/11/20 16:00:23] Asher Dino provided the following updates: Reduction of shielding from 7 to 3 days for Endoscopy procedure. Endoscopy Unit open 6 days a week.	Minor (2)	Possible (3)	6	Low	01/12/2020
2643	16/09/2019	Patient Risk (Quality)	Underwood, Victoria	Berns, Mrs Nicola	Medical Director	16	High	There is a risk that patients are unable to access safe and effective diagnostic imaging at the trust to service level standards which may affect their clinical care, due to insufficient staff in diagnostic imaging.	Capacity of radiology services. Specifically vacancies in Radiologists (Risk 2352), Radiographers (Risk 2273) and Sonographers (Risk 1750). The Trust has been without a substantive Manager for 2.5 years.	In patients: Delays in access to diagnostic imaging for emergecny patients can lead to delays for those patients and failure to meet 4h emergency care standard. 7 day operational services not routine leading to delays in inpatient care and discharge which impairs flow through the hospital. Out patients: Frequent breaches of the 6 week diagnostic standard. Limited access to timely high quality diagnostic imaging services could lead to further delays in patients pathways, particularly on RTT waiting times (Risk 956) and 2ww cancer pathways (Risk 2634). Access to ultrasound services for maternity patients requiring GROW scans (Risk 1750). Risk to patient safety if inadequate cover during out of hours services.	Interim Manager has recently been appointed. Interim Manager is reviewing current staffing and establishment against demand and capacity and it is likely that investment will be required to address this risk. Interim Manager completing Business Case relating to overseas recruitment. Radiologists - posts filled, however some are new to Consultant role or are in speciality doctor posts Sub-contracted radiology services (Everlight) are in use to provide additional radiology reporitng capacity and to support the reporting of images out of hours. Use of agency radiography staff.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:35:44] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:05:40] Risk reviewed and approved by Executive Lead in November 2020. The department is currently operating at 90% pre Covid capacity but significant skills shortages remain. [Burney, Mary 19/11/20 08:32:41] The service still struggles to meet demand with the available capacity. The service is working to improve rotas and working practices and reviewing skill mix to meet service needs. Outsourcing of MR and Ultrasound has commenced to deliver the backlog and additional resource for the reporting plain film to provide efficient service	Moderate (3)	Rare (1)	3	Low	01/01/2021
2679	15/11/2019	Patient Risk (Quality)	Schaefer, Heike	Meddings, Mrs Julie	Chief Nursing	12	Moderate	There is a risk that patients reaching the end of their life do not have an individualised plan of care (IPOC). This is a 'must do' recommendation from the CQC	Low numbers of patients with IPOC in place at end of life. Processes not consistently applied across trust for patients at end of life. IPOC process requiring review.	Poorly managed care and experience of patients at end of life. Patients suffering potential delays in symptom management on palliative pathways.	•Revised STP wide IPOC has been ratified at Medical records management committee on 24/02/2020. •Old IPOC now removed from all clinical areas and new IPOCS rolled during February. •Daily audit of the completion of existing IPOC in place •Training on the IPOC in place during Trust induction •Board round support by existing palliative care consultants •Matrons rounds and oversight and support for ward areas •Regular Trust wide support for ward staff by the EOL Facilitator •Revalidation of NACEL data submitted to national team. •EoL Steering Group in place (now Recognise & Respond Forum) •Revised end of life care strategy ratified at end of life steering group on 24/01/20. •Mini quality improvement project relating to End of Life care now undertaken with final event held on 21/01/20. .ReSPECT rollout undertaken March 2020.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:43:22] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 15:30:15] Risk reviewed by Executive Lead in November 2020. A review has been requested to confirm if the correct denominator of expected deaths is being utilised as opposed to all deaths. This will ensure that the reported figures are truly representative. [Meddings, Julie Mrs 10/11/20 15:56:45] 09/11/20 Meeting with Informatics and coding to review how the denominator can be updated to improve the quality of reporting. Proposal to Dr Raghu- Include only in-hospital deaths. Allocate a new Z code for IPOC. Either mandate the mortality reviews for all specialities or the ME can ascertain "expected" death. This takes place in frailty where 100% deaths have an IPOC Plan also to undertake an audit every 2 months to ascertain the quality of completion.	Moderate (3)	Possible (3)	9	Moderate	01/12/2020

2757	10/06/2020	Process / Corporate Risk	Jones, Ms Sarah	Jones, Ms Sarah	Chief Operating Officer	20	Extreme / Very High	There is a risk that patients may receive sub-optimal care/treatment due to potential failures associated with the Trust's Estate, Digital Infrastructure and Medical Equipment. This could affect the ability of the Trust to modernise the hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care. This could also impact the Trust's ability to acheive one of it's six strategic objectives (SO2).	Old hospital estate with significant backlog maintenance issues • Significant financial implications associated with further treatment of aligned risks such as roof • Many clinical areas known to need refurbishment, upgrades or improved layout or facilities Trust recognised as being digitally 'immature'. In 2019, the Trusts within the STP undertook a HIMSS Electronic Medical Record Adoption Model (EMRAM) Based on the assessment The EMRAM score for QEH was 0.03950. The national mean is 2.3.	Trust potentially unable to modernise the hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care. This could impact the Trust's ability to acheive one of it's six strategic objectives (SO2). This risk could impact the Trust's ability to move out of Special Measures. There is also a potential for Reputational damage – trust identified as technological 'laggard' though improvements realised as part of Trust's COVID response	• The Trust has submitted a case as part of the Health Infrastructure Plan 2 • The Spire Sandringham site has been acquired by the Trust • Capital Allocation has been made at an STP level and a Strategic Capital Board is in place with each organisation represented at Executive level. • An allocation has been made to the Trust with only prior year commitments and critical capital spend being approved whilst a detailed Capital Plan and Capital Programme is being developed. This programme aims to address critical backlog issues and investment requirements on a risk based assessment. Executive level monitoring of progress against the development of the plan and the expenditure incurred. • STP Digital Strategy, and Annual digital plan in place – NED engagement in STP workstream. • In partnership with STP colleagues, the Trust is on a journey to develop ICT technologies and transformational service solutions and has a clear digital roadmap for delivery for this financial year and beyond. This includes the implementation of RIS / EPMA as well as the development of business cases for E-Obs and a system wide EPR solution. • Cyber plan in place, cyber security reports and internal audits to Audit Committee and Board • Resources identified to deliver digital strategy and cyber plan BMI Sandringham has been acquired and will increase capacity for elective services.	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 19/11/20 12:25:30] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:15:58] Risk reviewed and approved by Executive Lead in November 2020. [Kahn, Mustafa 10/11/20 16:18:06] Risk reviewed and approved by Executive Lead in November 2020. The size of the estate may be unable to meet demand for the potential second wave of Covid-19. The BMI Sandringham site has been acquired by the Trust at the end of September 2020. This will reopen as an elective surgical centre as of 10 November 2020. Ward review and bed modelling has been undertaken to understand the inpatient bed requirement to deliver 92% occupancy.	Major (4)	Unlikely (2)	8	Moderate	01/12/2020
2759	11/06/2020	Process / Corporate Risk	Andrews, Robin	Andrews, Robin	Finance	12	Moderate	There is a risk that the Trust is unable to work effectively with patients and system partners to improve patient pathways. This could impact the Trust's ability to ensure clinical and financial sustainability.	Previous lack of partnership working. Historical challenges relating to trust size, location and role in local health economy. Trust in Special Measures which has affected reputation of trust.	Trust's ability to ensure clinical and financial sustainability. Trust's ability to achive strategic objective 4 (SO4).	• Actively engaged in the Hospital Services Strategy for Norfolk and Waveney working alongside NNUH and JPUH to deliver the key workstreams including specialty review and redesign and alignment of policies and procedures in light of COVID. This is in line with the principles of the Acute Services Integration programme whilst developing Phase 2 / 3 COVID response. • Monthly STP updates to Board. • Regular Board to Board meetings with CCG and acute partners. • Development and progression of Committees in Common. • SFIs and associated policies and procedures in place. • National guidance being followed in the absence of in-year control totals and national suspension of contracting and annual planning process. Monthly updates provided to Finance and Activity Committee on national guidance and the Trust's response. • Financial positon to M6 delivered in line with national guidelines. Trust has agreed out-turn position with NHS E/I, as part of the STP settlement for 20/21 • CIP plan delivering in year to support financial outturn • Positive cash flows based on national position to month 6 , and on agreed plan for months 7-12. • Capital expenditure plan agreed through STP and Trust in receipt of national funding. Significant capital programmes will be delivered in year	Major (4)	Likely (4)	16	High	[Kahn, Mustafa 10/11/20 15:38:36] Risk reviewed and approved by Executive Lead in November 2020. [Kahn, Mustafa 19/11/20 15:21:10] • Financial positon to M6 delivered in line with national guidelines. Trust has agreed out-turn position with NHS E/I, as part of the STP settlement for 20/21 • CIP plan delivering in year to support financial outturn • Positive cash flows based on national position to month 6 , and on agreed plan for months 7-12. • Capital expenditure plan agreed through STP and Trust in receipt of national funding. Significant capital programmes will be delivered in year • Trust has agreed a deficit position with the STP and NHSE/I for 20/21. Awaiting guidance on financial planning framework and settlement for 21/22 [Kahn, Mustafa 19/11/20 12:42:44] Risk reviewed at AREG in November 2020 and was approved to remain as graded.	Major (4)	Unlikely (2)	8	Moderate	01/12/2020
2199	10/12/2015	Patient Risk (Quality)	MacDuff, Miss Olivia	Harvey, Sarah	Chief Operating Officer	16	High	There is a risk that patient care and treatment could be delayed in the accident and emergency department due to a number of factors linked to capacity and demand. There is also an impact on patient experience in the department and the trusts ability to achieve the 4 hour waiting time target.	Delay in transfers of care. Limited number of discharges. GP refers to specialty. High demand on Emergency Services as a result of Sub-optimal patient flow across the Trust. Failure to discharge patients in a timely manner from the trust. Failure of admission avoidance schemes in the community.	Potential for adverse patient outcomes. Poor patient experience. Potential reputational damage. Potential financial penalties.	Robust escalation process in place. Governance structure and processes in place to respond to changes as they occur e.g. Daily capacity and flow meetings (inc. weekends), daily silver call. SDEC expansion opened on 13/01/2020. This has increased capacity for patients requiring same day care. The discharge lounge expansion opened 13/01/2020 and supports earlier discharge with the facility to take patients on beds. Separate Yellow and Green pathways in place to maintain flow for both patient cohorts. A data validation SOP for 4 hour breach reporting has been introduced. Emergency care improvement programme being developed to review pathways of care from pre-hospital to discharge with the aim to reduce delays and crowding.	Moderate (3)	Almost Certain (5)	15	High	[Kahn, Mustafa 19/11/20 12:39:26] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:07:11] Risk reviewed and approved by Executive Lead in November 2020. [Harvey, Sarah 29/10/20 08:55:27] Risk reviewed by DGM 29/10/2020 - current rating due to inconsistencies in performance.	Moderate (3)	Possible (3)	9	Moderate	01/12/2020
2343	02/09/2017	Financial & Estates Risks	Hall, Nigel	Hall, Nigel	Deputy Chief Executive	20	Extreme / Very High	Risk of disruption to the delivery of services, loss of confidential information,detrimental effect on the Trust's reputation, financial impact due to a cyber crime attack.	A malicious cyber-security related attack on the Trust's IT systems and information from an external or internal source.	Disruption to the delivery of services, loss or corruption of information, detrimental effect on the Trust's reputation, negative financial impact.	IT security policies/processes. Network perimeter firewalls and systems. IT security products i.e. Sophos anti virus/spam email, Websense web filltering. Staff awareness/communications. Software patch control. Strong access control i.e. user accounts/passwords. Business continuity plans. System back ups. IG Tool Kit. Digital strategy in place Annual cyber plan in place. Additional short term support is now in place to facilitate delivery of the strategy and plan.	Catastrophic (5)	Possible (3)	15	High	[Kahn, Mustafa 19/11/20 12:30:20] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:02:17] Risk reviewed and approved by Executive Lead in November 2020. [Kahn, Mustafa 04/11/20 11:16:47] Update from the Head of Digital - With the DSP Toolkit having been submitted with 12 outstanding areas that require addressing, our existing third-party support, Sapphire, have been briefed upon the position and been asked to provide options in relation to the design of a programme which will address the planning and risks rather than directly addressing the outcomes / recommendations of the recent Cyber Audit. Further, due to the lack of appointment following a round of interviews for the Cyber Manager post, the advert has been reissued. If further recruitment is not successful, alternate recruitment methods will be utilised.	Major (4)	Unlikely (2)	8	Moderate	01/12/2020

2699	05/03/2020	Patient Risk (Quality)	Coe, Mr David	Jones, Ms Sarah	Chief Operating Officer	20	Extreme / Very High	There is a risk that a Covid-19 pandemic will result in the trust being overwhelmed with an increase in infectious patients experiencing acute respiratory symptoms and requiring admission and/or intensive care. There is also a risk that a significant proportion of staff will experience sickness or be required to self-isolate or commence social distancing and be away from work. This could result in the hospital being unable to safely and effectively manage or isolate infectious patients and there is a risk that Trust cannot deliver its normal elective service.	COVID-19 poses a significant threat to the health of the population due to the ease with which it can be spread human to human by direct or indirect contact. The ability to travel easily to worldwide destinations has contributed to a pandemic occuring. Coronavirus COVID-19 has been declared as a pandemic	Primary Impact includes: Loss of staff due to illness or requirement to isolate, Excess casualties, Pressure on health organisations, Excess patients requiring ventilation, isoloation or intensive care. Excess fatalities. Impact on Trust's ability to deliver 'business as usual' services Secondary Impact: Psychological impacts, Economic impacts, Pressure on mortuary & funeral service providers and associated infrastructure.	The Trust has a Pandemic Plan and a Major Incident Plan in place, both of which have now been evoked with the COVID-19 pandemic being managed as a Major Incident. Governance arrangements have been strenthened with the COO as the Accountable Emergency Planning Officer. An Incident Control Team (ICT), comprising Execs and Divisional Directors(gold command). The Trust NHS EPRR incident levels remains at Level 3 (regional), having been stepped down from Level 4 (national) on 1 August 2020. A governance process around the management of the pandemic is also in place with action logs being completed in accordance with national and local directives. The Trust is participating fully in all relevant local and national reporting and escalation processes such as the Local Health Resilience partnership, teleconferences held by Government pandemic flu lead, regional meetings hosted by NHSE, gold/silver major incident command etc. A full communications plan is in place including regular staff communications, dedicated telephone lines and a COVID-19 intranet site with the latest government and public health information included. Specific and targeted communications are in place with BAME staff to help address specific risks and concerns associated with these staff groups. Relevant equipment and PPE are in place at the trust with 'fit' testing and training undertaken. A robust stock control process is in place with daily audits of PPE undertaken with local stock levels assessed with each division. An escalation process to the ICT is in place and PPE levels or concerns are included in daily sitreps and reported nationally every 24 hours. Current position regarding PPE is included in staff comms messages to respond to staff concerns. The Trust has taken action to identify and increase capacity in line with national directives. This includes reducing elective activity, undertaking Outpatient appointments and follow up consultations via phone or video conferencing. ITU and ventilator capacity has also been increased. Staffing arrangments and rotas have also been changed and developed to response to the pandemic. So far these measures are working well to increase available staff and capacity for COVID patients. Visiting restrictions are also in place at the hospital in order to minimise infection. As of 12/5/20 the Trust has started to move into the recovery phase, which involves incrementally resuming routine care. As of 11th May it was agreed that routine referrals into outpatients will resume and plans to safely restart non-urgent elective care will be developed. From this week, ICT meetings will now take place Monday, Wednesday and Friday. Comms updates will be issued after each meeting, rather than on a daily basis. as from 1 August the Trust complied with National guidelines to move into the third phase known as the recovery phase of the incident.The third phase of the NHS response to COVID-19 focuses on accelerating the return to near-normal levels of non-COVID health services. ICT meets once a week along with the two operational groups CP&SC and Workforce. all new national guidance is logged and action at ICT along with any local guidance from the operational groups. an operational group is meeting to ensure the Trust complies with phase 3 requirements of 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October and 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year Due to the increase in Covid patients the Incident Command team meets three times a week on Mon, Wed and Friday and the workforce, Patient experience and Clinical Preparedness teams meet twice a week on tuesday and thursday's. All actions are logged and signed off once action has been completed.	Catastrophic (5)	Possible (3)	15	High	[Kahn, Mustafa 19/11/20 12:28:32] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:00:53] Risk reviewed and approved by Executive Lead in November 2020. [Kahn, Mustafa 10/11/20 16:00:47] The Risk handler has advised that there is no change this month.	Catastrophic (5)	Rare (1)	5	Low	01/12/2020
2703	24/03/2020		McGuire, Mrs Karen	McGuire, Mrs Karen	Chief Operating Officer	20	Extreme / Very High	There is a risk that a significant proportion of staff will experience sickness or be required to self-isolate or commence social distancing and be away from work. This could result in the division's ability to treat patients safely and effectively being compromised.	Self isolation requirements. Staff directly affected with sickness.	This could result in the division being unable to safely and effectively manage or isolate infectious patients and deliver it's normal services or standards of care. Risk of ability to call patients due to sickness and isolation. This may also have an impact on skill mix on the wards.	Divisional management of staffing with collation of central professional register. Appropriate training underway. Redeployment register now being used. 'At risk' assessment of all staff in division now undertaken Review of senior medical cover undertaken for the whole division and ED workforce supported by others across the division. Review of nurse staffing undertaken across the division and staff released from other services to support ED nursing staff. Access to testing to allow 'self isolating' staff to return to work. Non-clinical staff (or those working at home) undertaking relevant tasks for clinical staff to release more clinical time.	Catastrophic (5)	Possible (3)	15	High	[McGuire, Karen Mrs 19/11/20 13:05:20] Reviewed by HON - No changes to scorings [Kahn, Mustafa 19/11/20 12:27:32] Risk reviewed at AREG in November 2020 and was approved to remain as graded. [Kahn, Mustafa 10/11/20 16:08:27] Risk reviewed and approved by Executive Lead in November 2020.	Catastrophic (5)	Rare (1)	5	Low	01/01/2021

2793	11/10/2020	Patient Risk (Quality)	McGuire, Mrs Karen	McGuire, Mrs Karen	Chief Nursing	16	High	Management of the needs of the increased numbers of enhanced care elderly patients admitted across acute access and medical wards a.Being unable, after allocation of health care assistant and registered nursing team to manage the enhanced care levels of monitoring required to keep patient groups as safe as possible, to then maintain appropriate cover across the rest of ward to consistently deliver to the remaining patients' needs b.Being unable to provide the required enhanced care support due to not all staff not being trained in this specialty and/or challenges in effective numbers of backfill nurses to the required numbers. c. Challenges with the acuity and numbers of enhanced care needs of the patients (in line with Trust policy) d. Difficulty in discharging some enhanced care patients due to the difficulty in accessing relevant beds/community care patients remain within the ward setting for long periods of time which is detrimental to their mental health status	1. Enhanced care patients require 1:1 care to maintain safety and ensure a high quality care experience from trained nursing staff. The increasing numbers of patients and the increased acuity of the patients needs has resulted in a challenge of large numbers of L3 or L4 care needs requirements on acute assessment/ward areas. 2. Often excessive numbers of enhanced care need patients to the resources available.	1. This can result in inconsistency in care delivery/patient experience to either the enhanced care patients and/or other patients fundamental care needs. 2. This could result in deterioration of the underlying enhanced care needs or physical health. 3. This could result in complaint. 4. This could result in accidental harm. 5. This could result in an overall increased LOS	1. Skill mix and establishment (actual vs planned) reviewed formally Twice daily but also at each handover and throughout the day/night, staffing is managed across the Division but also Cross Divisionally as required at the Twice daily staffing review. 2. Staffing review also includes acuity/dependency assessments. 3. Additional shifts are requested to bank/agency to support Enhanced care delivery. 4. Some ward areas have additional support in place eg PSW 5. Training has been completed for some staff on enhanced care support 6. Tiptree boxes available on some ward areas 7. Dementia friendly environments on some wards.	Moderate (3)	Almost Certain (5)	15	High	[Kahn, Mustafa 19/11/20 12:31:26] Risk reviewed at AREG in November 2020 and was approved to be added to the significant risk register. [Kahn, Mustafa 10/11/20 15:25:54] Risk approved by Chief Nurse in November 2020 to be submitted to AREG for inclusion on significant risk register.	Minor (2)	Possible (3)	6	Low	01/12/2020