Corporate Risk Register as at 20th November 2014

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan
T037	33. Corporate	Implementation of the 'Better Care Fund' agenda results in a significant net financial deficit to the Trust and/or inability to meet quality targets e.g. waiting times	Risk Assessment triggered by change of policy	Quality / Finance	Major 4	Likely 4	16	12	16	Treat	EMC	Director of Strategic Development / Cheif Executive	29/11/2013	31/01/2015	CQC - Responsive Strategic Objective 5	Work collaboratively and proactively with partners to develop plans for integrated care Increase CIP target for 2015/16 and develop plans Develop commercial strategy to identify other potential income sources
C&H008	40. Cardiology & Haematology	System for collecting patient care data for national mandatory audits is not robust and therefore cannot be relied upon to demonstrate quality of care resulting in potential failure to adhere to national guidance. This could affect the Trust reputation	Risk assessment	Quality / Strategy	Major 4	Likely 4	16	8	12	Treat	PRM and monthly governance meeting	Clinical Director	08/07/2014	31/12/2014		Quality Improvement project set up to devise integrated care pathway for acute coronary syndrome to be completed at point of care
T002	33. Corporate	Failure to deliver the Trusts long term productivity programme Linked to GS004	Business and Service Delivery Plans	Strategic	Major 4	Possible 3	12	9	12	Treat	FIC and Trust Board	Productivity Director	01/04/2012	31/03/2015	CQC Outcome 26 Principal Risk 8 Strategic Obj 4	CIPs in place for 5 years, which match QIPP plans. Risk rating of CIPs & QEIA process. Contingency CIP programme. PMO office established, with regular Productivity Programme Board held. Cross-cutting schemes to manage transformational changes. Monitoring at all FIC and Board meetings.
T038	33. Corporate	Security measures including staff and patient safety may be breached due to the lack of policy, training and resources around restraint, conflict resolution, potential absconding patients, property theft and panic alarms.	Assessment and amalgamation of local estates risk.	Health & Safety	Major 4	Possible 3	12	8	12	Treat	Directorate of Nursing; Health & Safety Committee; Security.	Director of Estates	11/02/2014	31/03/2015		- Measure for absconding patients are under review. - Policies still being prepared and ratified.
T_MAE003	12. Elderly Care	Risk of falls resulting in harm for specific highly vulnerable patients	Risk Assessment	Quality	Major 4	Possible 3	12	8	12	Treat	Performance Review Meeting	Service Line Manager Associate Director	27/03/2013	28/11/2014	CQC outcome 4 & 7 Principal Risk 1 Strategic Obj. 1	1. Accurate risk assessments to be carried out within 6 hrs of admission 2. ensure implementation of Fall Policy 3. RCA investigations for all moderate harm falls including action plans 4. Review number and severity of falls each month and analyse trends 5. Ensure monitoring of falls and post falls bundles. 6. Analyse co-relation between falls incidents and increase in the admission of over 75 years of age and length of stay. 7. Ensure effective night lighting
T009	33. Corporate	Risk that the Trust lacks the organisational capacity to deliver the large number of change programmes required.	Risk Assessment	Strategic	Moderate 3	Likely 4	12	6	12	Treat	AC	Director of Workforce & OD	27/12/2011	30/01/2015	Stategic Obj 2 CQC Outcome 14 Principal Risk 5 Priority Obj. 3	Management of SLM leadership development underway. Bottom up approach to developing CIPs for 2014/15. Budgets and plans for 2014/15 clarifying expectations and capacity required being developed at Service Line level. Training plan for CRS rollout developed. Market place developed for service lines and corporate departments.

T018	33. Corporate	Risk that handover of care to Out Of Hours (OOH) teams and provision of care at nights and weekends could compromise the ability to deliver the same quality of care as during normal working hours. Risk reworded October 2013 LINK: MAE_AM002: SP_001	Incidents / risk assessments	Quality	Major 4	Possible 3	12	6	12	Treat	Trust Steering Group QAC	Medical Director	01/01/2012	27/02/2015	Objective 1 CQC 16	Programme of work led by the Medical Director to address is underway. Work streams in Medicine and Surgery are in place to consider extended consultant days, weekend ward rounds, weekend diagnostics and further development of the Hospital at Night team. This is a Quality Account priority and will be monitored through that work stream Head of Nursing action plan Nursing review Emergency Standards action plan
T040	33. Corporate	Risks identified from the Frankham Consultancy Business Critical Review and the development of the Estates Strategy regarding the failure of engineering systems and buildings which are beyond their useful life may be realised.	Assessment and amalgamation of local risks	Finance / Stategy	Moderate 3	Likely 4	12	6	12	Treat	Trust Board Health & Safety Committee	Director of Estates	11/02/2014	31/03/2015	Outcome 10. Principal Risks 2 & 3. Strategic Objective 1	Capital Plan agreed.
T032	33. Corporate	Transition to SLM: Establishing Devolved Structure Transition to SLM could lead to reduction in control (eg. performance / finance) and other priorities getting pushed back. This is exacerbated by the fast pace Link to SLM009,SLM011, SLM010 and SLM012	GPG / EMC risk assessment Consultation document	Quality / Finance	Major 4	Possible 3	12	4	12	Treat	EMC	CEO	13/09/2013	31/12/2014		Recruitment to posts happening quickly. Training programme being devised and rolled out. Deployment of new governance structure. COO / DoF still reviewing performance Ensure knowledge and expertese not lost within Trust
T039	33. Corporate	Old patient monitors may fail as they are approximately 12 years old, estimated capital cost of replacement is £2.0m phased over 4 years. The current support contractor reports that these machines are difficult to maintain due to availability of parts. Areas that require new monitors are ITU, HDU, AAU, A&E, NNU, Paeds HDU, DSU recovery, Main Theatre Recovery and monitored beds on the wards.	Assessment and amalgamation of local risks.	Quality / Finance	Major 4	Possible 3	12	4	12	Treat	CIC	Director of Estates	11/02/2014	31/03/2015		- A business case is being prepared and is to be presented with an expenditure plan to commence in 2015/16 lasting for 4 years. - Increased stocks of spare parts are being obtained.
T_EST008	22. Estates	Esher Wing windows are distorted and overall are beyond their useful life. This materially affects the environment for patients in the wards in winter.		Quality	Major 4	Possible 3	12	4	12	Treat	Health & Safety Committee	Director of Estates and Facilities	21/10/2013	31/03/2015	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Investment is needed to replace the windows and associated fenestration. The replacement programme is being developed as part of the Estates Strategy.
T_IG005	25. Information Governance	Risk of ICO fines through data breaches e.g handover sheets not being properly disposed of, emails being sent to incorrect destinations		Financial	Major 4	Possible 3	12	4	12	Treat	Information Governance Committee	Finance Director	06/03/2012	31/03/2015	Objective 5	Actions from SIs being followed. Increase IG Training take up. BI not to put PID in emails. Briefing to be taken to Div Mgs Training Plan. Task & Finish Group created July 14 to look at why leakage of PID via email is occurring.
T_RAD013	19. Radiology	Lack of Radiology Department floor space and poor environment leading to adverse patient experience / dignity issues	Risk Assessment	Quality	Minor 2	Almost certain 5	10	2	10	Treat	Radiology Governance Committee	Radiology Manager	01/07/2014	05/12/2014	CQC Standard	To be discussed as part of Radiology 5 year strategy paper. Risk will only be fully mitigated with significant input from Estates. Poor reception facilities will be resolved within OPD Estates re-structure. Interim measures include discussion around clinical list management. Measures undertaken to improve the patient experience/dignity involve scheduling the patient lists e.g. to image paediatrics on seperate lists and in separate areas. Gynae lists occur in satellite units (Raynes Park/Surbiton) where there is a dedicated US area. Screens have been considered for IP privicy and used wherever possible. Encouragement for Patients to use double gowns and for CT patients to arrive for their scans in clothing with no metal on so they do not have to change and wait in a gown.

T021	33. Corporate	Risk to the quality of patient care from incomplete or unavailable health records LINK: AC_REC001, MAE_Ed002, SP004, AC_REC002, AC_REC003, IG008,	Risk assessment	Quality	Major 4	Likely 4	16	6	9	Treat	Patient Safety Committee QAC	Deputy Chief Executive	01/06/2011	31/03/2015	CQC Outcome 21 Principal Risk 1 Strategic Obj. 1	Health Records Improvement action plan developed lead by Project Manager. Regular audit programme.
T_EST002	22. Estates	Risk of non compliance with statutory requirements for fire alarm and detection systems, compartmentation, escape lighting, evacuation procedures and equipment and training. Link: SCC_TO006, TCS020	Risk Assessment	Health & Safety	Major 4	Likely 4	16	6	9	Treat	Health & Safety Committee AC	Director of Estates and Facilities	08/11/2011	31/01/2015	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Action plan in place to ensure recruitment to Fire Safety Manager, compartmentation survey, fire evacuation equipment purchase and replacement of Esher and Maternity Fire Alarm systems.
T007	33. Corporate	Failure to win tenders for secondary care input at outreach locations.	Business and service delivery plans	Strategic	Moderate 3	Likely 4	12	9	9	Treat	FIC	Director of Strategic Development	27/12/2011	31/01/2015	CQC outcome 26 Principal Risk 9 Strategic Obj. 4	Clear governance arrangements in place for development and approval of significant bids. Governance arrangements established to support development or bid in response to new tender.
T_RAD006	19. Radiology	Risk of inability to meet 6 week diagnostic target in ultrasound due to demand outstripping funded capacity. leading to possible delay in diagnosis/treatment and poor patient experience.		Quality	Moderate 3	Likely 4	12	6	9	Treat	Radilogy Governance Committee	Radiology Service Manager	01/06/2012	05/12/2014		Staff are working extra hours in order to provide a service. Radiology ultra sound are currently back filling Plan on going recruitment of obstetric sonography staff. Planning for an increase in obstetric sonography workload. Agency sonographers are brought in to provide required capacity. 18/11/2013- Extra clinics with Locum sonographers put in place. Time recource is being used for Patient Tracking list which is reviewed weekly.
T008	33. Corporate	Competition from other providers affects the Trust's income position and financial viability	Business and service delivery plans	Strategic	Moderate 3	Likely 4	12	6	9	Treat	AC	Director of Strategic Development	27/12/2011	31/01/2015	CQC outcome 26 Principal Risk 9 Strategic Obj. 5	Development of Commercial Strategy. Implementation of Commercial Strategy action plan. GP engagement.
T033	33. Corporate	Transition to SLM: Skills Development Risk that the staff (Managers and Clinicians) do not have the skills and time to support SLM during the transition Link to SLM007 and SLM006	GPG/EMC risk assessment Consultation document	Quality / Finance	Moderate 3	Likely 4	12	3	9	Treat	EMC	CEO	13/09/2013	31/12/2014		•Management and leadership development programme •Coaching programme •Internal training •Review of short term interim support for clinicians and managers new to post
T036	33. Corporate	Risk to the Trust's reputation if the Friends & Family Test inpatient scores remain nationally in the bottom quartile.	Identified during RMC meeting then subsequently assessed	Quality	Moderate 3	Likely 4	12	3	9	Treat	EMC/Patient Safety Committee	Director of Nursing & Patient Experience	07/10/2013	30/01/2015	CQC Outcome 1 Strategic Objective 1	(1) Weekly review of FFT comments for wards. (2) Review learning from questions regarding what patients would like us to improve. (3) Implement Patient Experience Action Plan. (4) Implement revised national requirements for FFT including stopping companion with other organisations.

T043	33. Corporate	The lack of robust Cancer tracking systems and processes will result in poor reporting against indicators, impacting on the Trust's reputation, compliance with regulators (CQC and Monitor), and poor patient experience.	Risk Assessment of service	Quality	Moderate 3	Likely 4	12	3	9	Treat	PTL Meeting	Deputy CEO	14/10/2014	30/01/2015	Safety SO1	Escalation meetings in place twice weekly. Performance monitored at PTL Meetings.
T_AC_PAT0019	17. Pathology	Lack of progress in SWL SAP plan is impacting on staffing in Pathology. Instability in the system is affecting morale resulting in staff leaving and diffculty in recruiting, impacting on the ability to deliver a reliable 24 hour service. Shortages could impact on our accreditation status.	Risk Assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	Performance Review Meeting	Associate Director, Division of Clinical Support	17/05/2013	14/12/2014	CQC outcome 13 Principal Risk 1, 2 & 5 Priority Obj. 3 Strategic Obj. 1, 2, 3 & 4	1)Workforce plan being developed to predict potential staff loses and to ensure early recruitment interventions 2)Workforce plan and pay budget monitoring will predict budgetary impacts will ensure Pathology / Division is aware of fiscal pressures and develop mitigation plans where possible 3)Pathology KPI's developed to monitor impacts to QMS 4) SWL Pathology have devised actions to reduce restrictions on recruitment process.
T006	33. Corporate	Failure of QIPP Action plan to achieve the reduction in volumes expected by GPs and CCGs resulting in financial tensions in the local health economy This risk is defined to relate to 2014/15 primarily	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	FIC	Finance Director	04/04/2013	12/12/2014	CQC outcome 26 Principal Risk7 & 9 Strategic Obj. 3 & 4	The Trust and CCG have used the BSBV process to align plans for growth & QIPP for 2014/15 Co-ordinating all interactions on demand management with the Trust through the contracts team and disseminating from there. Initiate and complete Q1 SLA reconciliation
T012	33. Corporate	Risk that partnerships do not deliver anticipated benefits	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	AC FIC Trust Board	Chief Executive	01/12/2011	30/12/2014	CQC outcome 6 & 26 Principal Risk 7 Strategic Obj. 3	Continue review of all external partnership contracts as per Corporate Objectives 14/15 Continue to participate as a full partner in SWL Pathology Programme to oversee the delivery of the identified benefits
T016	33. Corporate	Risk that implementation of CIPs adversely affects the quality of patient care and the patient experience. Link: MAE_ED007	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	Trust Board	Productivity Director	01/12/2011	31/03/2015	CQC outcome 16 Principal Risk 1 Strategic Obj. 1 & 5	- Quality impact assessment of all CIP schemes, now to include assessment of impact to other departments/teams. - Dashboard/visual presentation of KPIs to be developed and monitored in PMO. - Development and monitoring through QIWG, QAC and Trust Board.

T025	33. Corporate	Poor compliance of mandatory training resulting in staff being potentially out of date with current practice LINK: T_AM004, GS001	Internal audits	Quality	Moderate 3	Possible 3	9	6	9	Treat	Executive Management Committee QAC	Director of Workforce & OD	06/03/2012	16/01/2015	CQC Outcome 13, 14 principla Risk 5 Priority Obj. 3 Strategic Obj. 2	1. Managers to plan attendance on training sessions. 2. To escalate to the Director of Workforce any difficulties in securing places on training. 3. Managers to follow up on non attendances. 4. To impose the policy which means that staff cannot attend any other training until their mandatory training is complete. 5. Arrange group training where this is appropriate/possible. 6. Monitoring of compliance by EMC weekly. 7. Make mandatory training uptake part of SLM authorisation.
T045	33. Corporate	Failure to demonstrate a robust process for Do Not Attempt Resuscitation Orders will result in non compliance with regulators expectations and impact on the Trust's reputation and may lead to litigation.	Risk Assessment against internal audit report	Quality	Moderate 3	Possible 3	9	6	9	Treat	Quality Improvement Working Group	Lead Resuscitation Officer / Head of Clinical Audit & Effectiveness	14/10/2014	31/12/2014	Safety / Effectiveness / Caring / Responsive SO1	- Review and revise where appropriate the 'Do Not Attempt Resuscitation Policy'. - Complete leaflet for patients and disseminate. - Discuss issue at Quality Improvement Working Group. - Medical Director to email all consultants. - Re-audit / regular monitoring.
T_HR009	24. Human Resources	Risk that the Trust will be unable to deliver the cultural change necessary to support change and that staff do not feel able to influence decisions about delivery of services.	National Staff survey	Strategic	Moderate 3	Possible 3	9	6	9	Treat	AC	Director of Human Resources	10/04/2012	08/03/2015	CQC outcome 12 & 14 Principal Risk 1, 5 & 6 Priority Obj. 3 Strategic Obj. 1 & 2	OD programme and Workforce Strategy progressed. Workforce strategy refreshed November 2013. Staff survey 2013 evidenced more engaged staff. Appraisal underway.
T_MAE_AM016	12. Elderly Care	Risk of not being able to provide adequate acute capacity because of delayed transfer of care.		Quality	Moderate 3	Possible 3	9	6	9	Treat	Performance Review Meeting	Therapy manager	24/01/2013	28/11/2014	CQC outcome 4 & 7 Principal Risk 1 & 2 Strategic Obj. 1	1. To ensure that mdts are held on each ward to expedite decisions and discharges 2. To pilot MDT ward rounds. 3. To redesign 10 days length of stay meetings. 4. To incorporate DTOC into CQUIN
T_MAE_AM023	12. Elderly Care	The failure to provide assessment to those frail elderly patients who are not cared for on the CoE wards may result in sub-optimal care e.g. longer length of stay, delay in commencement of appropriate medical plan.	Risk Assessment	Quality	Moderate 3	Possible 3	9	4	9	Treat	Service Line Governance Meeting	AD - Emergency Services	24/01/2014	19/12/2014	Safe; Caring; Effective	1. To review the system for buddying CoE Consultants with other wards and ensure that the system is formalised. 2. To agree with the General Surgery SLM what CoE support is required and to work with them to develop a case for increased resource. 3. To develop a business case for the appointment of an additional CoE Consultant to provide inreach to AAU/A&E.
T042	33. Corporate	Some Trust procedural documents are past their review date, which may result in current best practice not being followed, impacting on the Trust's reputation, as well as, resulting in poor patient and staff experience.	Risk Assessment	Quality	Moderate 3	Possible 3	9	3	9	Treat	Compliance & Risk Committee Clinical Quality Improvement Committee	Head of Corporate Affairs/Corporate Risk Manager	14/10/2014	31/12/2014	Safety/Well Led SO 1	SLs being encouraged to reduce the number of document where possible so their portfolios are easier to manage. Divisional Directors are being kept informed of the number of outstanding documents in their SLs so they can influence the Service Managers.
T_EST004	22. Estates	Risk of enforcement action under the electricity at work regulations because of non compliant electrical infrastructure including lack of suitable UPS and IPS in high risk patient areas. Link:TCS005, TCS001	Risk Assessment	Health & Safety	Major 4	Likely 4	16	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	17/01/2012	31/03/2015	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Policy for management of electrical installations to be drafted and competency of staff undertaking electrical work to be established. Further funding needs identifying to install UPS/IPS in High risk patient areas including Main theatres and Maternity.
T044	33. Corporate	Risk of insufficient numbers of nurses and/or with sufficient skills required to meet acuity/dependency and care needs of patients. This could also lead to the Safe Staffing guidance not being met which then has a potential for adverse local and national media coverage which could impact on the Trust's reputation.	Risk Assessment	Quality	Major 4	Possible 3	12	8	8	Treat	Safe Staffing Group	Director of Nursing & Patient Experience	14/10/2014	31/01/2015	Safety / Caring / Well Led SO1 / SO2	- Safe Staffing policy to be approved which includes escalation process. Draft approved in Sept 2014. - Philippines recruitment to take place - expected to start in Jan 2015. - New starters c100 registered nurses and nursing assistances to start Sept - Nov 2014. - Weekly pay bank staff to increase the bank availability - starts Oct 2014. - Retention plan required - to be developed.
T003	33. Corporate	Work to reconfigure unviable services elsewhere in cluster will impact adversely on KHT	Business and Service Delivery Plans	Strategic	Major 4	Possible 3	12	4	8	Treat	AC	Director of Strategic Development	01/04/2012	31/01/2015	CQC outcome 26 Principal risk 9 Strategic Obj 3 & 5	- Refresh 5 year business plan. - Participate in SWL Strategy development. - Maintain flexibility to respond to any emergent changes in demand as required.
T028	33. Corporate	The failure to control the occurrence of C.diff resulting in poor outcomes and experience for our patients	Infection control - incidents	Quality	Major 4	Possible 3	12	4	8	Treat	EMC	Director of Nursing & Patient experience	06/12/2012	30/01/2015	Outcome 8 Principal Risk /BAF 1, 2, 8 Strategic Obj. 1	Implementation of 2013 peer review action plan: Action plan in place following Dec 13 Peer Review visit. the action plan listing all actions is available as required. Review learning from infection PIRs to determine any additional actions to be taken.

T_EST005	22. Estates	Management of legionella and water: potential in water systems for debris from corroded pipework and risk of legionella bacteria.	Risk Assessment	Health & Safety	Major 4	Possible 3	12	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	07/02/2012	31/03/2015	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Investment is needed to replace old pipe work and up grade the water system to further prevent and reduce bacteria count. Further replacement pipework planned 2012/13 and 2013/14. 01/09/14 (HG update) - works in Esher wing will be paused in November due to operational requirements and will re-start in May 2015.
T_EST026	22. Estates	Increased Energy Prices - Volatile Energy Prices. At present estates energy budget is 2.5million. The price increase has the potential to have a large financial impact.	Energy Supply & Demand	Financial	Major 4	Possible 3	12	4	8	Treat	Estates	Director of Estates & facilities	01/01/2013	31/03/2015		Follow Trust Carbon Management Plan
T031	33. Corporate	Failure to meet Monitor requirements resulting in breach of licence Link to T029	Risk Assessment	Strategic	Major 4	Unlikely 2	8	4	8	Tolerate	Trust Board, APSG, FIC	Chief Executive / Head of Corporate Affairs	04/06/2013	30/01/2015	Principal Risk 2 & 8 Strategic Obj. 5	•Board review against Licence in March 2013 •Board re-reviews planned •Process for submitting ¼ ly returns reviewed by APSG, FIC & Board •Weekly review performance against targets at EMC •Cancer action plan monitored at Divisional Board •HCIA action plan
T035	33. Corporate	Transition to SLM: Interrelationship Risks that the service lines, corporate services and supporting IT do not move at the same pace. Risk that SL inter-relationships stay under-developed for too long. Risk that the pace of SL development is too slow Link to SLM002,SLM003, SLM004 and SLM005	GPG / EMC risk assessment Consultation document	Quality / Finance	Minor 2	Likely 4	8	2	8	Treat	EMC	Director of Finance Director of Strategic Development Head of Quality & Risk Assurance Head of Information Services	13/09/2013	30/01/2015		Re-alignment of roles within corporate teams Recruitment in BI team 'Lot 4' of OD programme • Management of accreditation pipeline. • Provide training for all Clinical Directors. • Ensure pace of change is as fast as practically possible. • Ensure effective governance of the implementation of SLM.

Progress Against Action Plan
02/14 - Discussions are ongoing with partners. - 2015/16 CIP plan has been developed. - The Commercial Strategy if being refreshed for March 2014. 03/14 - CRC reviewed the risk and agreed to reduce the consequence score to 4 from 5 reducing the overall risk score 16 from 20. 06/14 - Discussions are ongoing with partners. Anticipated losses have been reflected in our LTFM. CIP plan for 15/16 to be developed by Dec 14. Commercial strategy approved by Board May 14. 11/14 - Reviewed by RB - Discussion are ongoing with partners. Anticipated losses have been reflected in our LTFM. CIP plan for 2015/16 under development-completion planned for 2015/16. Commercial strategy action plan developed and on track-reviewed at Strategy Committee quarterly.
7.10.14. MG quality improvement project working group meeting monthly to introduce ICP that will collect data for mandatory audit. Clinical Nurse Specialist for ACS collecting part data. Identified issue re incorrect data entry for last audit so as not to replicate in this year's data
CIPs finalised as part of 2014/15 budget setting and were presented to Trust Dev Forum 22/4/13. Monitoring process under review. Monthly Commercial & Productivity Project Monitoring Group held to date and quality impact of productivity programme monitored at QAC. New Dashboard developed to bring together financial and quality KPIs. Under performing schemes in year replaced by newly developed schemes. 12/13 - Schemes are currently being worked up with Service Lines for the 2014/15 programme. Each clinical division has been allocated an Executive lead to support the development of their programme with meetings to review ideas commencing early December. Finance teams will support their service lines with the development of the schemes. The PMO will co-ordinate and review the programme and ensure the quality and equality impact assessments are completed for each scheme. 06/14 - Schemes underway and being monitored. 09/14 - Schemes being monitored and delivered year to date. Budget setting for 14/15, including development and refinement of CIPs by service line, has commenced.
* Conflict resolution Training is now at acceptable levels (particularly amongst clinical staff) – above 75% * Lone Worker Devices/Panic Alarms are available and being used by appropriate persons * Thefts remain an issue but we are no longer classed as a crime hotspot by the police. - Restraint training for security officers in place. 11/11/14 HG - Policy remains outstanding due to challenges relating to recent DoH guidance preventing ratification. Use of lone worker devices is under review by the Health and Safety Committee, further restraint training is required for Trust staff once the DoH guidance has been clarified.
05/06/2014 SE: The use of falls alarms in toilets and with commodes has been successful and is now been rolled out to all CoE wards. 21/08/14 TM - no change
OD programme approved by Trust Board. Programmes being monitored by EMC. CRS planning complete but implementation delayed. Pathology (SWLP) approved. Leadership development partner appointed and programme started. Business planning process for 2014/15 simplified. 02/14 - DG reviewed and changes made. 07/14 - Reviewed by TR - no change 11/14 – TR reviewed

Trust Steering Group to monitor workstream progress in place, work plan agreed and in progress. 10/13; risk re-worded and score increased 12/13 - No change to risk score. Broader OOH issues are being addressed by the Deputy CEO. 12/06/14 Reviewed by JKW - - HaN QIP being handled and monitored through QW/G – will report to CQIC and QAC - New rotas being implemented - Technological solution to handover task to business case 07/11/14 (JW) - MPages handover solution in development with Cerner to manage live handover patient lists, Rag rated priority and task list. Junior doctor rotas altered Aug 2014. New rotas will be requited August 2015. Site team and Outreach nursing team being developed. Operational Flow policy in development.
04/14 - Capital Plan agreed and out put will be reviewed at the Capital Investment Committee, progress review September 2014 11/11/14 HG -Progress on target as part of 5 year plan.
11/13 Recruitment complete although some new post holders are yeat to start. New governance structure in place and first meetings are being held. Trainees identified and dates set for budget training. 12/13 Associate Director for Specialist Services now started. 02/14 Reviewed by NH - no update. 06/14 - Reviewed by NH - Structure being embedded through OD work and performance regime. Recruitment continues. 09/14 - Further to discussions and analysis, new Exec structure being introduced to improve assurance and mitigate risk.
Preparation of the business case is underway. 13/08/14 HG - No change 11/11/14 HG - BC is going through approval process.
For this winter, new blinds and additional heaters are being sourced. 21/3/14 HG reviewed - For this winter, new blinds and additional heaters were sourced and the weather was mild all of which mitigated the risk for winter 2013/14. HG update 09/06/2014 Planning permission to change the new windows has been applied for and tender documentation is being prepared. Works are currently planned to commence in April 2015. 13/08/14 HG - No change 11/11/14 HG - Tenders are being sought
Note: Initially scored 8 however due to recent SI, this was increased to 12. 11/13 - Score to remain as 12. 12/13 - 2 presentations on topic at Team Brief; training modified to emphasise PID risks; will discuss risk score at the next IGC 04/14 - Reviewed by SM - no change at present but will review shortly as risk is being discussed at IGC. 06/14 - Reviewed by SM - Score to remain the same as a new breach has occurred. A task & finish group is to be created to work to reduce the breaches. Group will sit under IGC. 09/14 - Reviewed by SM - T&F Group findings propose a way forward. Methodology accepted by IGC and SI Group. Further testing to be rolled Sept 14 and implemented Oct14. Risk held unchanged till proposals fully implemented. 11/14 - Reviewed by NB - New encryption software still being tested but going well. Aim to fully rollout by mid Dec 14.
First strategy meeting took place 04/07/14 Market testing meeting set up for 19/11/14 Middle office restructure works are undergoing so an 2 room US hub with Changing Room facitilities will be created 20/10/14 New secretarial office hub awaiting network connection. Once completed works can begin on Ultrasound hub. 07/11/14

Action plan delivered. Currently receiving notes within the Health Records to further improve flow of notes to departments 07/13; - Improvements in performance noted at the Health Record Programme Board - work continues. 10/13; staffing has been increased permanently to address previous shortfall. 05/14 - SLs to update the Health Records Manager (HRM) of all HR risks to ensure they are linked with the HR RR and managed holistically. 6/14 - SLs still to update on their records risks. HRM updating the HR Group of levels of engagement from SLs. 19/11/2014 - HRM monitoring risk monthly and working with SLs to capture all their risks.
Fire Safety Manager in place. Fire evacuation equipment in place. Compartmentation completed. Esher Wing fire alarm replacement programme completed, Maternity to follow. 10/13: Fire Response Team now in place and training completed. 10 minute fire delay call to LFB now in place as agreed at RMC. 21/03/14 - HG reviewed, no new update. 10/06/14 - HG reviewed, no new update. 11/11/14 HG - Issue with Fire doors identified in Kingston Surgical Centre will be resolved by end November 2014.
04/14 - Reviewed by RB - All current actions have been delivered and risk is as low as it can get. Target risk increased to 9 as it can never reach 6. Risk will be tolerated as the residual risk will remain. Re-consider whether it should be closed next quarter. 06/14 - Re-considered and decision made to leave open. 11/14 - Reviewed by RB but no change
13/02/14 Action plan progressing as forecast. Breach numbers reducing. Demand management in place for MSK requests. Meetings held with Kingston & Richmond CCGs. Capacity forecast and planned against for 2014/15 contracting round. New Radiology sonographer starts end Feb 2014 to enable work at Surbiton HC. Maternity Ultrasound staffing improved (no agency planned so far from 01/04/14). 2 Trainees qualify 2014. Breach position much improved with diagnostic waiting list compliance forecast from 1st April 2014 (96% w/e 16/03/14). JW 20/03/14 08/04/14 JW Compliance not yet achieved (97%) due to increased demand against plan during March (by about 200 requests). Updated action plan to manage new residual backlog (61 patients) required to meet standards at end of April. 05.09.14 Performance 98.1% (action plan for compliance within Sept)29/10/14 Performance for end October 99.8% achieved through extra consultant lists and clerical overtime work to keep backlog in check. 28/04/14 compliance at 96% as demand above `contracted`plan in April by 500 02/06/14 compliance at 99%+ (target met) 08/07/14 Performance 98.5% 01/10/14 compliance at 99%+ (target met) 01/11/14 compliance at 99.8% (target met)
04/14 - Ongoing GP engagement. 06/14 - Reviewed by RB - Commercial Strategy approved by May 2014 Board. 11/14 - Reviewed by RB - Performance against commercial strategy and stakeholder engagement reviewed at Strategy Committee quarterly
Wave 1 of coaching training commenced. Internal training in development. 11/13 Management and leadership development programme providers selected and programme under development. 02/14 Reviewed by NH - Leadership programme commenced. 06/14 - Reviewed by NH - OD and coaching programmes ongoing with specific support tailored to individual services lines as required. 09/14 - Leadership programmes continuing, supported by specific technical and leadership interventions at service line level. Additional corporate support put into areas of concern, where performance is not consistently of a high enough standard.
03/14 - The quarterly qualitative analysis of FFT comments now in place from Feb 14 pending greater granulation of information for wards or areas of focus. Programmes of work to improve food and assistance with meals in place. Safe staffing programme in place to address staffing perceptions. 06/14 - New inpatient experience action plan approved by Trust Board in May 2014. 09/14 - Reviewed by DB - score reduced to 9 from 12 as the national guidance has changed to move away from hospital to hospital comparisons of FFT scores, preferring internal benchmarking only. Although the guidance has changed there is still a residual risk. People will compare scores so left at likelihood of 3 as the overall inpatient FFT scores have not yet improved consistently.

14/10/14 - (TM) Twice weekly escalation meetings continue. 19/11/14 - Reviewed by NF - Action plan has been adjusted to take into account feedback from LCA visit. This was reviewed at EMC this week and progress is good on resolving the outstanding issues. MDT coordinators are being devolved into the service lines with full competencies and training packages. Pathways are being agreed for each tumour site to include clear escalation points. Performance for October is much improved to earlier in the year.
17/05/2013 1)Using staff plan predictive tool work within sector HR plan to re-distribute staff resource or activity across sector to match demand to capacity 2)If SW London sector cannot support early transfer of resource / demand – Seek support from non-sector NHS providers or private providers as required 3)Transfer cold services at risk to SW London hub in advance of planned timescale – Requires assurance of HR process and development of infrastructure and sector capacity Success of strategy will vary dependent upon pathology discipline 20/09/13 SE Internal and external factors are reducing the effectiveness of the action plan. Retaining as many former employees as possible on bank roll to cover OOH service. To be reviewed towards end Nov 13 on account of TUPE consultation conclusion. 13/12/2013- the risk is that it still presents a risk to service sustainability – but it is being managed at KHFT by a strong recruitment programme and agency staff. Presently working on a plan to maintain accreditation status but there will be non compliances identified 22/8/14 JW Staffing level in Clinical Biochemistry/Immunology is at no risk, posts filled for daily as well as OOH. Microbiology OOH has moved onto hub site and daily workforce is not at risk. Haematology/Blood Transfusion is not to plan, 2x Band 6 and 3x Band 5 unfilled, affecting the workload commitments and putting at risk the OOH rota.
RISK INCLUDES T010 WHICH IS NOW CLOSED (30/11/2012) SM CCGs have articulated a certain degree of specificity for QIPP schemes for 2014/15. 04/14 - Reviewed by SM - Risk description changed to bring the risk up to date and to reflect 2014/15. No other updates. 06/14 - Reviewed by SM - No current update. 09/14 - Reviewed by SM - changes made. 11/14 - Reviewed by NB - Q1 rec has 4 outstanding items where CCGs are challenging whether they should pay as billed. KHFT are rebutting these challenges.
All partnership contracts reviewed, including external due diligence of SWLEOC. Outcomes of these reviews were presented to FIC and Trust Board where appropriate. Actions were agreed where necessary. CEO is SRO of SWL Pathology Programme. Regular updates to Trust Board. Ventures & Partnership Risk Register is being created at which point this overarching risk will be replaced with specific risks
Quality impact assessment and challenge sessions for all CIPs underway. Quality indicators identified, and monitoring dashboard under development for presentation at June PPB. 12/13 The newly formed Quality Improvement Working Group (QIWG) will provide assurance that the Cost Improvement Programme will not adversely affect the quality of care provided. Quality and Equality Impact Assessments (QEIAs) will initially be reviewed within service lines, then by the PMO prior to being signed off by the QIWG. Any schemes for which there are concerns about the quality impact following this process will be returned to the service line to mitigate any risks to quality. 05/14 (TF) - All schemes challenged and assessed for effects on quality at budget review meetings, formal QEIA reports now being finalised and will initially be reviewed by the Productivity Team with any requiring clinical review considered at the QIWG. Quality indicators have been identified and monitoring dashboard under development. 6/14 - Reviewed by NH - QEIAs reviewed and some escalated to QIWG for further scrutiny.

Overall uptake currently 69% (Feb 2014). Manager accountability strengthened with SLM. On line training re-launched. PDR check of compliance. IG training available on-line. Reports available by service line. 02/14 - DG reviewed and made changes. 07/14 - TR/DN reviewed and changes made. 11/14 (TR) - Stat Mand booklets have been developed to overcome access issues and enable staff to complete training in user friendly way. Divisional Directors are now holding service lines to account.
14/10/14 (TM) - Actions underway. 19/11/14 - Actions progressing, no new updates.
04/14 - OD programme and Workforce Strategy has progressed together with the implementation of the Ashridge Management Development programme, focusing on leadership. Workforce strategy 2012- 2018 was refreshed in January 2014 . Staff survey 2013 evidenced more engaged staff but more work to do with middle managers. Appraisals take place annually. Appraisal cycle is currently underway.
10/06/2014 SE Weekly meetings with the Dy. CEO have been introduced to review perticularly long waiters and escalation has improved. As a result the number of patients medically fit for 10 days+ awaiting discharge has reduced.
21/08/14 TM - The buddying system for consultants is now well established and working well with Lilian Choy linked with Hardy, Louise Hogh, Hamble and Robin McNAbb Bronte wards. A scoping exercise for provision of care of the elderly input in surgery has been completed and resources are now being sourced by the surgical service line. The business case for an additional care of the elderly consultant is in progress. A review of care provided to care of the elderly patients on specialist medical wards is being presented to QAC September 2014. 07/11/14 A review of the Care of the elderly risk register is planned for the 18th November , the support for no CoE wards within medicine continues and a buisiness case for in-reach to surgery is being considered alongside the service lines vision for 2015/16 .
14/10/14 - (TM) Action plan in place and being worked through to manage and assist the SLs to review their procedural documents.
New generator installed. Electrical Infrastructure work to be commenced in Esher Wing in 2013/14 as per Estates Maintenance Plan. 10/13; work currently being planned. 05/14 (HG) - Design engineers appointed. 11/11/14 HG - Tenders for phase 1 of the works under review.
14/10/14 - (TM) - Recruitment plan in place, including overseas recruitment. - Safe Staffing Group in place to oversee work plan. - Monitoring of staffing in place daily. - Agency and bank staff available as required and available.
- Work has commenced to support development plan by June 2014. - Awaiting details regarding the BSBV. 06/14 - Reviewed by RB - 5 year strategic plan approved by Trust Board in June 2014. - Ongoing engagement with SWL Commissioning Collaborative on SWL Strategy development. 11/14 - Reviewed by RB - Ongoing engagement with SWL Commissioning Collaborative and SEL Provider Collaborative.
06/14 - Overall number of C.Diff cases for the first 6 months of 2014 have reduced from prior year. Action plan continues to be implemented. Root cause analysis in place for any cases. 09/14 - Reviewed by DB and action added.

Some pipework replaced in 2011/12. Rigorous, robust monitoring of legionella undertaken weekly. Water testing carried out routinely for bacteria and management system in place for treating any findings. Pro-active flushing, tmv, removing dead legs and treating. Quarterly audits by external contractor, Water safety meetings monitoring actions from testing. 21/03/14 HG reviewed - Contractor has commenced work on main system and pipework within Esher Wing contract will continue in 2014/15. Proposals for Outpatients building being developed. Flushing regime data records 80% compliance. 10/06/14 - HG reviewed, no new update. 10/06/14 - HG reviewed, no new update. 01/09/14 (HG Review) - Work continues in Esher Wing, (45% completed) tenders to be issued for Main Outpatient building late September. Risk score remains unchanged. 11/11/14 HG -Work in Esher Wing 75% complete.
Gas prices have increased by over 50% in the past 3 years and are likely to keep on rising. Energy consumption across the Trust would continue to increase owing to more staff and more services been rendered. Investment in Energy efficient pojects set in the Trust Carbon Management Plan would ensure reduction in energy consumption and costs. A few of energy efficient projects have been carried out and business cases for some of the projects are been prepared to ensure rduction in energy consumptiom and set emissions targets are met. Trust has recently lauched a sustainability steering committe whose aims are to ensute energy comsumption are mitigated Trust wide through energy awareness behaviourail change programmes and implementation of energy efficinecy projects. External funding for these projects is also been sought through organisations such as Salix Energy Efficiency Scheme Loan. 05/14 (HG) - Raising awareness, consultants being appraised. 11/07/14 (HG) - Carbon Credentials have been appointed to run an awareness campaign. Energy reduction scheme to install insulation to pipework in plant rooms is in progress. 11/11/14 HG - Review of Dalkia energy use in progress
•Ensure maintenance of performance targets to protect Quality Governance Rating •Regular agenda items at :EMC, Trust Board, FIC and QAC •RAF paper and presentation to Board September 2013 to outline the compliance changes 12/13 - A Quality Governance Review has taken place and the update is going to the January Board. 03/14 - DL updated - In the Quarter 3 call with Monitor they confirmed they had given a green for governance and were satisfied around C.Diff. 01/05/14 (DL) - Board review against Monitor license carried out on the 30th April 14. Self certificates going to FIC and the Board in May for the 1st submission and in June for the 2nd submission. 12/06/14 (DL) - Self Certificates went to the Board. Plans in place to maintain compliance throughout the year. Evidence reviewed for the Corporate Governance statement at the end of the year. 07/11/14 (DL) - The Board undertook a mid-year review against the License conditions on November 5th 2014. A further discussion will take place at the January Board and the annual review will take place in April 2015.
Corporate team roles clarified. BI team interviews underway. "Lot 4" of OD probramme tender returns shortlisted. Accreditation pipeline under development. Internal and external training for CDs under development. Pace of change already commenced with structural and governance changes in place. SLM implementation risk register developed. 11/13 Finance, BIU and Ulysses systems mapped to new structure. 02/14 Reviewed by NH - no update. 6/14 - Reviewed by NH - SLM Steering Group monitoring progress of implementation and timetable for accreditation. 11/14 - Reviewed by NB - 7 SLs have now been accredited. Programme in place to complete all by Mar 15.