Entire Corporate Risk Register Report showing all risks at 18 - 01 - 16

Kingston Hospital NHS
NHS Foundation Trust

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	Target Date	CQC Outcome / BAF	Action Plan	Progress Against 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	31/03/2016	30/12/2016 00:00:00	Outcome 10. Principal Risks 2 & 3. Strategic Objective 1	Capital Plan agreed.	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. April 15 (HG) - 2nd year of programme agreed at Capital Investment Committee and approved as part of Capital plan 2015/16. August 2015 (HG) works planning in progress. Oct 15 (HG) Works for 2015/16 in progress and preparation of 2016/17 capital plan will commence in late Q3.
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	29/01/2016	03/04/2017 00:00:00	Safe, Caring, Effectiveness, Responsive & Strategic Objectives 1 & 5	Discussed as part of Radiology 5 year strategy paper. An integregral part of Radiology Hospital accreditation process (Clinical Governance element) Risk will only be fully mitigated with significant input from Estates and Finance. 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. If possible Gynae lists occur in satellite units 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 so they don't have to change. Aware of inadequate mixed sex and in/out patient areas - but will require significant estates and financial input.	Works so far include one US room now operational the 2nd room is dependent on OPD project Discussed at RGM on 14/9/15 to chase estates for the store cupboards to be built AJT Discussed at RGM on 26/10/15 No change to reception - Although Radiology cannot change the position of their department in relation to A&E the MES contract due to be taken out in 2016 might have the opportunity to change some of the environmental features for the benefit of the patients. OP project to recommence in Radiology from 18th January 2015 with a new reception area. Workable solution for mixed sex issues found estates department involvement required needing significant financial input. Project scoped, awaiting Estates quote in order to take to next stages.
T_EST_CE013	22. Estates	Radiology Gamma Camera beyond useful life. Technical Failure of Current Gamma Camera leading to Patient Cancellation and Radiation Dosage Risks. Linked to T_RAD016	Internal Risk Assessment	Quality / Strategy	Major 4	Likely 4	16	9	9	Treat	Estates	Director of Estates & Facilities	08/07/2015	31/03/2016	30/12/2016 00:00:00	Safe, Responsive & Caring Strategic Obj 1	Solution being looked for under lease option with Finance & Purchasing. 21.09.15 (HG) Establish a way to replace the machine. Assess impact on cancer targets	08/15 (HG) - Scheme to be assessed as initial indications suggest that cost will exceed £1.0m 13.01.16 (SS/JF) About to go out to market for a managed equipment service.
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	31/03/2016	29/12/2017 00:00:00	Safe 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.	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. 02/15 - HG reviewed - All issues in Surgical Centre Resolved. Survey of Esher Wing undertaken and minor works are being undertaken to be completed by end of March 15. 12/05/15 All main fire compartments in Esher Wing complete. Sub-compartment survey underway and works commencing in phases. Main site wide fire alarm signalling system to be ungraded Q4 2015/16. 08/15 (HG) - No change 12/15 (HG) - site wide signalling scheduled for 2016/17, the level of Fire Training needs to improve across staff..
T_HR0016	24. Human Resources	Risk of Trust being unable to recruit staff and retain current staff.	Service Audit	Quality	Major 4	Likely 4	16	9	9	Treat	Workforce Committee & Executive Management Committee (EMC)	Director of Workforce	21/12/2014	31/01/2016	30/12/2016 00:00:00	Caring, Safety, Effectiveness & Well-led Strategic Objectives 1, 2 & 5	Employment of new staff - Communication - Giving experience to new staff Integration Recruitment and Retention unable to sustain the workforce Replacement of experienced staff who leave New staff support Pay inequality	Short-term No Cover Fill Rate not 100%, currently less than 70% & 50% for HCA's Recruitment Plan in place Happy Staff Objective in place as part of Retention Programme. 24.12.15 (PH/DT) Re-designed recruitment process running from the 11th Dec 2015 as it`s quicker and more effcient than the old process as its underpinned by more engagement with managers. Training with recruiting managers has started as well (briefing them on good recruitment process).

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																Communication: Staff engagement is reduced if we do not communicate the right message. Staff engagement is measured through the national annual staff survey.		
T_MAE_AM016	12. Elderly Care	Risk of not being able to provide adequate acute capacity because of delayed transfer of care.Inadequate systems and processes to progress patients to discharge due to patient flow issues.	Risk Assessment	Quality	Moderate 3	Likely 4	12	3	9	Treat	Weekly DTOC Meeting Governance Meeting Performance Review Meeting	Director of Operations	24/01/2013	31/01/2016	27/01/2017 00:00:00	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. Implement golden patient programme - Enhanced patient flow 5. To incorporate DTOC into CQUIN 6. Pilot ward for D2A project Dec 2014 7. Develop consultant lead 7/7 ward round / service 8. Implement golden Patient across all wards . 9. Implement breaking the cycle week .	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. 02/12/14 - TD - Risk reviewed and updated 16/02/15 - Golden patient implemended and embedded on Pilot ward (Blyht) , rolled out across remiaing wards . model of Care in coE under review . Risk reviewed and updated . 02/04/15 - risk reviewed - TD / LH - Breaking the cycle week planned . Plan to take D2A project to Orthopedics. 14/08/15 - Risk reviewed TD / LH– risk remains, risk score remains 9 ,D2A project moved to Orthopedics . Actions appropriate. 09.11.15 (HD) From 26/11/15 Daily Meetings held at 10.15am to discuss all delays to discharge. Wards sisters in attendance and patients that may be a pending delay also discussed. Borough Social Workers in attendance. Actions and named responsible person allocated.
T_THER001	14. Therapies	Results of weighed in-patient audit revealed that Patients are not being served target portion sizes and also consuming much less on ward level than the minimum recommmendations for protein and energy inteke. This can result in patients not meeting nutritional requirement which can cause weight loss, malnutrition, poor wound healing and increase in LOS.	In-patient weighed food audit carried out by dietetics	Quality	Moderate 3	Possible 3	9	6	9	Treat	Monthly performance meeting with Caroline Bracewell	Dietetics	17/09/2015	20/01/2016	30/12/2016 00:00:00	Safety, Caring, effectiveness & Responsive Stragic Objective 1	1.Provision of a light meal or fortified soup and bread for patients with a very small appetite. 2.Increase intake of between meal snacks by providing training to ward staff and for ISS staff to be responsible for giving out snacks with mid pm drink. 3. Re-launch Fracture Neck of Femure Nutritional Pathway on Ortho wards 4. Trust should adhere to the nutritional standards and portion sizes set out in the current catering contract. approved by Tracey Moore to add as a score of 9	1. Action plans in place and dietetics working with Facilities and now serving recommended portion sizes. Completed 2. NOF Nutritional Pathway will be fully re-launced by September 2014 3. In discussion with Director of Nursing about how to deliver effective training on the wards through the nutrition steering group. On-going 4. Dietetics and ISS in close liaison and working on various menu, meal and snack improvements. On-going 4/3/15 (CC) Re audit carried out 3/3/15- awaiting results from audit office. All other actions completed. On-going.
T002	33. Corporate	Failure to meet the Trusts long term CIP requirements. Linked to GS004	Business and Service Delivery Plans	Strategic	Major 4	Likely 4	16	9	9	Treat	FIC and Trust Board	Director of Strategic Development	01/04/2012	15/01/2016	31/12/2016 00:00:00	CQC Well Led 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. Contract negotiation with commissioners with a view to securing additional support for underfunded services from monies made available from Autumn Statement 2014. Budget setting timetable. Service Line data analysis support. SWL collaborative work. Monitoring by FIC and the Trust Board.	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. 01/15 - Reviewed by RB. Robust processes have identified c50% of CIP requirement for 2015/16 with limited scope for further savings given level of cash releasing savings achieved over past 5 years and RCI of 83 (most efficient acute Trust in the country). Likelihood score has therefore increased. New cross cutting schemes have been established in relation to length of stay, theatre productivity and procurement. High level contracting meeting planned with commissioners to discuss position and potential for additional funding. 03/15 reviewed by RB. c80% CIP requirement for 15/16 identified. Plans for years 2-5 not identified as focus has been on year 1 which has proved challenging. Further work to be undertaken on longer term plan in 2015/16, taking into account insights from external review by PwC 10/15 RB - Risk wording amended. Budget setting timetable for 16/17 agreed. Data packs on profit and loss, utilisation and benchmarking data at a granular level to support productivity planning distributed to Service Lines August 2015 and meetings taking place with Service Lines during Q3 2015 to identify opportunities. Opportunities are also being progressed through wider SWL work.
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	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	FIC	Finance Director	04/04/2013	31/03/2016	31/12/2016 00:00:00	Safety, Effective and Responsive 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. 28.10.15 (VC) Relationship building with commissioners and agreed process to review and understand activity. Clear communication to commissioners when their QIPP plans are considered unrealistic or lacking in delivery plan that these reductions are at commissioner risk Initiate and complete Q1 SLA reconciliation	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. 02/15 - Reviewed by NB - CCGs are seeking a year end settlement agreement for 2014/15. 06/15 - Full review and reassessment of this risk being undertaken by JF which will then go to FIC for approval. 28.10.15 (VC) Ongoing challenge review monthly with commissioners. Working jointly to understand activity and to close down challenges.

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T025	33. Corporate	Poor compliance of mandatory training resulting in staff being potentially out of date with current practice	Internal audits	Quality	Moderate 3	Possible 3	9	6	9	Treat	Executive Management Committee QAC	Director of Workforce & OD	06/03/2012	31/03/2016	29/12/2016 00:00:00	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. 8. Determine whether other user friendly ways of completing mandatory training can be developed.	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. 02/15 - Reviewed by DD - Despite Booklet compliance increasing gradually and lower than expected. Dates for F2F sessions available throughout 2015. High DNA's on F2F sessions Managers emailed. Trainers have been going directly to some Depts. to deliver sessions. Workforce reports of compliance remain visible for staff. Awaiting implementation of WIRED (?March/April) for easier viewing and accuracy. Senior managers emailed to advise of low compliance and how to access training for staff. 05/15 (TR) - Planning for 15/16 underway 07.01.16 (PH/DT) Action plan has been done & options have been identified and presented to EMC. HR is currently doing a trajectory to which will enable managers to be informed when staff are close to being out-of-date with training.
T_ATDS008	04. Anae / Theatre / DSU	Potential risk of patients falling off patient trolleys in DSU due to mechanical failures during positioning for surgery and staff injuries due to manual handling incidents. All 30 trolleys in DSU were purchased more than 20 years ago. Due to wear and tear they have mechanical faults posing risks to patients and staff. The trolleys were due to be replaced in April 2015 from capital funding but the funds were diverted to other higher priority causes at the time. Currently high BMI patients cannot be operated in DSU resulting in delays and inefficiencies. As from January 2016, the trolleys will be out of contract and obsolete. Any faulty trolleys will not be repaired and will have to be taken out of circulation resulting in loss of activity and income	Risk assessment and clinical incidents	Health & Safety	Major 4	Possible 3	12	8	8	Treat	Service Line - monthly PRM	DSU Clinical Operations Manager	30/07/2015	30/04/2016	30/04/2016 00:00:00	Safe, Caring, Effectiveness, Responsive & Strategic Objective 1	1. Requests funding to purchase 30 new trollies. 2. Business case to be submitted to Capital group by PK in September 2015. 3. Trollies have been trialled and quotations are with PK.	Dec 2015 - Trolleys in good working order and under maintenance contract until July 2016. However repairs cannot be guaranteed as it will depend on parts availability as these trolleys are now obsolete and this could mean that broken trolleys will be taken out of circulation. The current risk has reduced to 8. It is likely that funding for new trolleys will be available in April 2016.
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	31/03/2016	30/06/2020 00:00:00	Safe 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.	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. April 2015 (HG) - Phase 1 complete. Phase 2 out to tender. 08/15 (HG) - Phase 2 tenders being appraised. 12/15 (HG) - Tenders not viable and scheme being reconsidered for 2016/17.
T_EST005	22. Estates	Management of legionella and water: potential in water systems for debris from corroded	Risk Assessment	Health & Safety	Major 4	Possible 3	12	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	07/02/2012	31/03/2016	30/03/2018 00:00:00	Safe & Effective Strategic Obj. 1	Investment is needed to replace old pipework and upgrade the water system to further prevent and reduce bacteria count. Further replacement pipework planned 2012/13 and 2013/14.	Some pipework replaced in 2011/12. Rigorous 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

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		pipework and risk of legionella bacteria.															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.	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. 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. 04/15 (HG) - Works plan under review. 08/15 (HG) - Works in OPD out to tender. 10/15 (HG) - Tenderers raised queries and tender levels were unacceptable. The queries are being addressed and tenders will be re-issued in Q4.
T_HR017	24. Human Resources	Risk of Trust being unable to provide Trust accommodation to new starters in particular Overseas nurses as demand is outstripping supply.	Service Audit	Health & Safety	Major 4	Possible 3	12	4	8	Treat	Workforce Committee	Terry Roberts & Hugh Gosling	06/11/2015	31/12/2015	30/12/2016 00:00:00	Caring, Safety, Effectiveness & Well-led Strategic Objectives 1, 2 & 5	Re-assess for current residents in Trust accommodation and issuing notice to current tennants. - We have acquired rooms from a neighbouring Trust. - We have asked Estate to build a portfolio of accommodation (Mixed Economy) - Proposal to appoint an accommodation officer to manage this.	So far, we have sourced additional accommodation, worked with Meridian to protect rooms for new starters and have re-assessed the criteria for new tenants. 24.12.15 (DT) Currently no accommodation. Risk raised to 12.
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	Incidents	Financial	Major 4	Possible 3	12	8	8	Treat	Information Governance Committee	Finance Director	06/03/2012	31/03/2016	31/01/2017 00:00:00	Safety Strategic Objective 5	Actions Plans from SIs being followed up/monitored. SophosEmailAlert blocking PID. Monitoring of [NOPID] usage. IGC monitoring inclidents	06/15 - Encryption Software in place. Blocking System In place [NOPID] bypass in place. There have been incidents of deliberate bypass of blocking system with [NOPID]. Monitoring continues. 09/15 - (JS) further SI not picked up by blocking - algorithym refined. Continuing mis-use of [NIOPID] 12/15 - No fine from ICO following deliberate [NOPID] breach
T_MAE003	12. Elderly Care	Risk of failing to prevent avoidable falls resulting in potential harm for specific highly vulnerable patients Risk re-worded 23/02/15	Risk Assessment	Quality	Major 4	Possible 3	12	8	8	Treat	Governance Meeting Performance Review Meeting Trust Falls Group SIG	Service Line Manager Matron Clinical Director	01/04/2012	31/01/2016	29/12/2017 00:00:00	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 8. To improve photography of wounds . 9. Increase nursing leadership on the wards . 10 Impelmentation of pre-completed profoirma for ward rounds to ensure the risk of falling is higlighted to medical staff . 11. Ensure Elderly Care representation at Trsut Falls Group 12. Ensure that post falls document is completed in following a fall so that post falls review is undertaken. 13. Ensure that falls with fracture are reported as a safeguarding.	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 02/12/14 - Falls rates and any SI actions reviewed monthly at Governance Meeting. 23/02/15 - SWARM has been trilaed on Kennet ward - learning and impementation across remaining wards to be discussed at next Governance SLM . 02/04/15 - TD / LH - Risk reviewed . Action to implement SWARM removed , not felt by clinical staff to be as helpfull as anticipated. Focus of the service line is to improve performace against the current actions. Addition on action to increse nursing leadership - to be achieved through buisiness planning process 14/08/15 - Risk reviewed at Service Line Meeting .Actions 10 ,11, 12, 13 added .Falls remain a concern. In addtion it was noted that there is no falls training on induction ,this has beeen fed back to the falls group 13/08/15. It was also higlighted that there is limited knowlege of how to complete the the post falls document in CRS - this has been fed back to the CRS ops Lead 14/08/15 . risk score remains the same . 09.11.15 (HD) Falls training delivered at MDT – training offered to all clinical and nursing staff within the service line – Plan to continue High Risk Icon developed for all patients over 65, icon developed to distinguish VERY high Risk COE representative now attends Trust Falls group To trial nursing transfer checklist (on CRS) from AAU to Keats (initially)
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	15/01/2016	31/12/2016 00:00:00	CQC Well Led Strategic Obj 3	- Refresh 5 year business plan. - Participate in SWL Strategy development. - Maintain flexibility to respond to any emergent changes in demand as required.	- 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 SWL Provider Collaborative. 02/15 - RB reviewed - Money for Acute Provider Collaborative agreed by Board, Programme Director appointed and project plan developed with input from Trust. 10/15 RB - Trust fully engaged in wider review across SWL and Surrey Downs to support affordability.
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	31/01/2016	31/12/2016 00:00:00	Outcome 8 Principal Risk /BAF 1, 2, 8 Strategic Obj. 1	Actions implemented as per PIR findings. Actions in place regarding infection control training and systems of assurance regarding antibiotic management, cleaning and isolation. Reported through IPCG. 14/09/15 Continue to review Post Infection Review (PIR) findings through Serious Incident Group as required and IPCG Implement actions arising from PIR findings Monitor & audit antibiotic usage Monitor cleaning & hand hygiene scores across all areas of the Trust and take action as required to improve any deficits in	06/14 - Overall number of C.Diff cases for 2014/15 have reduced from prior year. Root cause analysis in place for any cases. 09/14 - Reviewed by DB and action added. 03/15 - DB - RCAs are reviewed with SCU infection control team. So far 2013 peer review action plan has been implemented and this has been re-reviewed by CQRG. 05/15 - Overall number of C.Diff cases for 2014/15 have reduced from prior year with one lapse in care noted. Root cause analysis in place for any cases. C.diff action plan has been implemented. Infection control priorities in place for 15/16 and to be presented to the Trust Board in June 2013 as part of annual infection control report. New actions will be identified through the PIR process 14/09/15 - 2 lapses of care out of total of 9 reported cases for 2015/16 ytd Actions in place in

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																	performance Monitor and agree any lases of care with CSU infection control team Infection control policies in place and presented to Trust Board in infection control annual report	response to these. Review of cdiff cases presented to September CQIC All infection control policies & procedures are in date Peer review for all hand hygiene audits introduced from September 2015 to strengthen hand hygiene compliance monitoring Antibiotic audit programme taking place.
T031	33. Corporate	Failure to meet Monitor requirements resulting in breach of licence	Risk Assessment	Strategic	Major 4	Likely 4	16	8	8	Treat	Trust Board, APSG, FIC, EMC	Chief Executive / Head of Corporate Affairs	04/06/2013	29/01/2016	31/12/2016 00:00:00	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 Cancer Board & EMC •"patient flow out" plan under development •Financial recovery plan under development	•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. 02/15 - Reviewed by DL - An internal review of effectiveness against the Well Led Framework will take place in Feb, supported by KPMG. 11/5/15 (KG/SS) Likelihood increased due to Q4 results. Consequences decreased due to context. Monitoring adjusted to include EMC. Review of 'better grip' under way. 23.07.15 (SS/DT) Consequence increase due to Monitor investigation. Financial recovery plan, A&E Transformation and Cancer Strategy to mitigate risk. 13.10.15 (SS/DT) The Board approved reduction due to close working with Monitor and other external partners. 6.1.16 (SS/DT) Recommendation from CRC to reduce likelihood as Monitor investigation now closed.
T037	33. Corporate	Implementation of the 'out of hospital' agenda/five year forward view results in a significant net financial deficit to the Trust. Mar & Oct 15 - Risk description amended by RB.	Risk Assessment triggered by change of policy	Quality / Finance	Major 4	Likely 4	16	4	8	Treat	EMC	Director of Strategic Development / Cheif Executive	29/11/2013	15/01/2016	30/12/2016 00:00:00	CQC - Responsive Strategic Objective 3.	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	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. 02/15 - RB reviewed - No evidence of significant activity reduction to date or plans which are anticipated to result in significant losses in the short term. Likelihood score therefore reduced to 3. Update on actions are as the Nov 14 update. 11/03 Reviewed by RB - Close working with GPs and other partners in Richmond and Kingston to develop new models collaboratively. 10/15 RB - as 11/03. Work is continuing
T044	33. Corporate	Risk of insufficient numbers of substantive nurses and/or with sufficient skills required to meet acuity/dependency and care needs of patients and therefore lead to harm /poor patient experience. This could also lead to the Safe Staffing guidance not being met which then has a potential for breach of CQC standards.	Risk Assessment	Quality	Major 4	Possible 3	12	4	8	Treat	Safe Staffing Group	Director of Nursing & Patient Experience	14/10/2014	30/01/2016	28/12/2016 00:00:00	Safety / Caring / Well Led SO1 / SO2	• Safe staffing policies in place • Safe staffing group reviews recruitment and staffing actions • Overseas & UK based recruitment plans in place • Weekly reviews of vacancies and recruitment activity at Safe staffing meeting • Weekly assessment centres in place • Safe staffing data collection in place *Internal audit undertaking a review of safe staffing data collection in 2015/16 *Establish registered nurse rotation programme from October 2015 *Planned timetable of nursing assistant recruitment Commission further Aspriing sister/charge nurse programme to aid recruitment into sister/charge nurse roles *International recruitment budget in place for 15/16 Bid for additional funds from HESL to support preceptorship and reduction in turnover *Monitor staff exit questionnaires to aid turnover reduction	*14/09/15 - Currently c.200 nurses, midwives, nursing assistants recruited and awaiting to start in the organisation dependent upon necessary checks, and requirements to be met to confirm starts *Timetable of nursing assistant recruitment events in place for remainder of 2015 *Further international recruitment to India, Philipines, & Portugal in October & November 2015 taking place *£14k additional preceptorship funds provided by HESL - awaiting ouctome of 2 further bids for funding to support programmes *Further aspiring sister/charge nurse programme commenced in September 2015 and will last until December 2015 *Nurse rotation programme commences in October 2015 with 12 candidates confirmed

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T_ATDS003	04. Anae / Theatre / DSU	Patients operations could be delayed, cancelled, theatre turn around will be prolonged because of shortage of surgical instruments. This could result in poor patient experience, possible poor surgical outcomes, poor theatre utilisation, waiting times breaches, complaints and loss of income.	Clinical incidents, internal report, equipment audit and business case.	Quality / Finance	Moderate 3	Possible 3	9	6	6	Treat	Service line perfomance review meeting	Service Manager	09/07/2014	30/04/2016	22/12/2016 00:00:00	Safe, Caring, Effectiveness & Strategic Objective 1	List planning and assessing equipment requirements. Fast tracking and borrowing as required. Business case to be submitted and accepted requesting a capital investment to purchase identified equipment to manage current activity.	RP - 03/09/14. Plan for case to be submitted end Sep 14. RP: 5/12/2014 This risk affects surgery service lines and SSD. Review in April 2015. TM - 20/02/15 - Escalated to the Corporate Risk Register.RP- 13/05/2015 - Risk is managed by SSD manager. Business case approved. To review time frames for purchase and installing track and trace system with SSD manager. 28/08/15 - CIC approved a phased approach to instrument purchase. So far £150k has been spent on high priority instruments thereby reducing risk from 12 to 9. An updated equipment list will be resubmitted to CIC in September 2015 requesting funding for the next phase of purchase. Dec 2015 - There is an agreed planned capital investment for £230k required for additional instruments, starting with £100k in April 2016.
T_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	6	6	Treat	PRM and monthly governance meeting	Clinical Director	08/07/2014	29/02/2016	30/12/2016 00:00:00	Safety, Caring, Effective & Responsive Strategic Objective 1 & 2	Quality Improvement project set up to devise integrated care pathway for acute coronary syndrome to be completed at point of care	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. 31.12.14. MG Quality Improvement Project working group continues to meet and CD has met with CRS leads to discuss options available for automatic collection of certain data points e.g. medications and bloods by CRS. Positive outcome. 14.4.15. MG authorisation given to recruit part time audit data entry post. This will improve data collection and as the postholder will be part of the Cardiology team they will have greater insight into the quality of data collected. 5.10.15. MG audit assistant has been appointed and commencing data entry. Cardiology Registrar has started on ICP and first draft with CD 4.10.15. In addition two heart failure nurses have been appointed, one started October to assist with audit entry 14.12.15. MG risk reduced in light of above appointments
T_EST026	22. Estates	Increased Energy Prices - Volatile Energy Prices. At present Estates energy budget is 2.5 million. The price increase has the potential to have a large financial impact.	Energy Supply & Demand	Financial	Major 4	Possible 3	12	6	6	Treat	Estates	Director of Estates & Facilities	01/01/2013	31/03/2016	30/06/2016 00:00:00	Effective Strategic Objs. 3 & 5	Follow Trust Carbon Management Plan	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 being rendered. Investment in Energy efficient projects set in the Trust Carbon Management Plan would ensure reduction in energy consumption and costs. A few of the energy efficient projects have been carried out and business cases for some of the projects are been prepared to ensure reduction in energy consumptiom and set emissions targets are met. Trust has recently launched a sustainability steering committe whose aims are to ensure energy comsumptions are mitigated Trust wide through energy awareness, behavioural change programmes and implementation of energy efficiency projects. External funding for these projects is also being 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. 04/15 (HG) - Review still in progress 08/15 (HG) - Review still in progress
T_HR009	24. Human Resources	The potential inability of the Trust to emerge as an Employer of Choice. This may lead to lower staff motivation, a poorly managed workforce, high turnover and poor delivery of patient-centred care.	National Staff survey	Strategic	Moderate 3	Possible 3	9	3	6	Treat	Workforce Committee AC	Director of Workforce and OD Directorate	10/04/2012	31/01/2016	29/12/2017 00:00:00	Caring, Safety, Effectiveness & Well-led Strategic Objectives 2 & 5	PMO approach taken to address cultural change necessary to support change. External resources to be brought in to facilitate and help manage change. Positivity programme developed to improve the narrative and engage staff.	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. Staff survey evidenced more engaged staff but more work to do with middle managers. Appraisals take place annually. More focus on staff to part-take in staff survey. PMO approach agreed at EMC. Management Development rolling programme initiated Dec 2015.
T_RAD016	19. Radiology	Risk of a potential CQC reportable radiation incident as a result of gamma counter camera breakdown. Linked to T_EST_CE013.	Risk Assessment	Health & Safety	Major 4	Possible 3	12	6	6	Treat	Radiology Governance Committee	Radiology Service Manager Clinical Lead for Radiology	21/07/2014	29/01/2016	30/06/2016 00:00:00	Safe, Responsive, Effective, Caring & Strategy Objective 2	Radiology communicate with other radiology providers in an attempt to have the nuclear measurement scan carried out off site post nuclear medicine injection. Gamma camera to be replaced during 2016/17	Radiology has an agreement with Parkside and St Georges so that in the event of a breakdown the patients will be where possible scanned at the above hospitals. There is internal progress to replace the gammer camera as detailed in RAD 001 16/11/14- Risk likelihood increased to 3 due to a radiation incident occuring in August 2014. On review- the original score of 4 x 1 was not appropriate as it was set too low for the estimated possible frequency of such an incident recurring. 26/1/15 This is now on the Trust Register. 26/10/2015 Discussed at RGM - The Gamma camera replacement will now be part of the MES project. - Business case was taken to Capital Investment Committee - in principle they have agreed to fund the replacement which should occur in 2016/17 following discussion with Radiology that it would be acceptable to leave the replacement until next financial year. AJT

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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	6	Treat	EMC	Director of Strategic Development	27/12/2011	15/01/2016	29/12/2016 00:00:00	CQC Well Led Strategic Obj. 4	Development of Commercial Strategy. Implementation of Commercial Strategy action plan. GP engagement.	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 02/15 - RB reviewed but no further update. 10/15 RB - Commercial Strategy approved by the Board, May 2015. Market share reviewed on a quarterly basis - no significant reductions identified.
T018	33. Corporate	Risk that information systems cannot provide live clinical information on patients that is prioritised and describes clinical tasks and therefore poor handover. Risk reworded January 2015	Incidents / risk assessments	Quality	Moderate 3	Unlikely 2	6	6	6	Treat	QAC	Medical Director	01/01/2012	29/02/2016	30/11/2016 00:00:00	Objective 1 CQC 16	M page development. Clinical champion identified.	Jan 15 - Project scoped and worked commenced with Cerner. Feb 15 - The M Page is built and testing starts at the end of Feb 15. 21.08.15 (JW) Mpages has now been introduced so risk can be reduced. 14.12.15 (JW) Risk reviewed but remains the same.
T019	33. Corporate	Risk of inadequate training of staff in use of medical devices	Risk Assessment	Quality	Major 4	Possible 3	12	3	6	Treat	Patient Safety Committee	DoN&PE	01/09/2012	31/03/2016	29/12/2016 00:00:00		Recruit Medical Device Training Coordinator and develop education programme Link practitioners being identified for all areas Self assessment competencies introduced equipment Training inputted on OLM Competencies for high risk to be completed.	Database of Medical Devices established. Sub-divided into High, Medium and Low risk and by department. Competencies for high risk devices have been written and collection of training data has started Self-assessment evidence for medium and low risk devices is being collected Training data is being added to OLM For all new equipment, devices will not be released from clinical engineering until there is a minimum of 70% of staff trained on that device Medical Device Link Nurses established in each area. Shared folder on the w drive set up for Link nurses and ward managers to have access to inventories, training data, competencies etc.
T020	33. Corporate	Potential for non-compliance with Health Act Code of Practice in respect of infection prevention and control	CQC / risk assessment	Quality	Catastrophic 5	Possible 3	15	6	6	Tolerate	CRC QAC	DoN&PE	01/04/2012	31/03/2016	30/12/2016 00:00:00	CQC 8, Objective 1	Reduction in targets has increased potential for breach, therefore, programme of environmental audits and equipment cleaning in place. Specific action plans for C Diff. Included in Frontline Focus plan.	Monthly audits indicate improved commode cleaning and hand hygiene. Latest PEAT inspection produced favourable results for infection control measures. HealthAssure evidence compliant. Postive CQC Compliance report. Quality Trust Board reports show compliance.
T022	33. Corporate	Risk that Trust will be unable to deliver CQUINS targets	Business and service delivery plans	Strategic	Moderate 3	Possible 3	9	6	6	Treat	CQUIN Board AC	COO	01/12/2011	31/03/2016	28/12/2016 00:00:00	Safety, Effective and Responsive Strategic Objective 1	Robust plan developed to achieve at risk targets and monitoring process by monthly CQUIN Board.	10/13; Plans developed and being monitored at monthly CQUIN Board. Q1 currently with Commissioners for confirmation of achievement. 02.09.15 (ED) Risk reviewed, no change & current controls maintained. 04.01.16 (ED/DT) Risk reviewed but remains the same.
T023	33. Corporate	Failure to deliver the 18 week RTT target, resulting in patients waiting longer for treatment.	Business and servide delivery plans	Strategic	Moderate 3	Possible 3	9	6	6	Tolerate	PTL Board AC	COO	11/01/2011	31/05/2016	31/12/2016 00:00:00	Safety, Effective and Responsive Strategic Objective 1	Weekly monitoring of 18 week RTT at PTL meeting. Weekly reporting to EMC. Broader range of KPIs to monitor performance.	Targets now being met. Delivering across teh Trust, focus work in Oral and Gastro to address residual back log. Weekly monitoring and data cleansing in place. 02.09.15 (ED) Risk reviewed, no change & current controls maintained. 04.01.16 (ED/DT) Risk Reviewed but remains the same.
T024	33. Corporate	Failure to comply with the six criteria for meeting the needs of people with a learning disability (based on the Healthcare for All Report recommendations 2008)	Recommendations from other high level enquiries and reports	Quality	Major 4	Possible 3	12	6	6	Tolerate	Patient Safety Committee QAC	DoN&PE	01/12/2011	08/09/2016	31/12/2016 00:00:00	Safety, Responsive and Well-led Strategic Objective 4	* Establish protocol to guide practice when patient admitted and flagged on CRS or with a LD passport * Update A&E protocols to reflect patient journey * Development of 'easy read' information on common treatment options for wards, and for letters to patient. * Develop protocols for representation of LD patient or carers on appropriate forums and audit processes * Re-audit of DoLs to include LD patients * Audit of LD passport to be developed * Review of learning from other organisations in relation to LD	Action plan completed 14/09/15: Continue to monitor via Safeguarding committee and annual review of Monitor declaration requirements.
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	6	Treat	Compliance & Risk Committee Clinical Quality Improvement Committee Executive Management Committee	Head of Corporate Affairs/Corporate Risk Manager	14/10/2014	29/01/2016	29/12/2016 00:00:00	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. The following control measures have been put in place to mitigate this risk: - Reminder emails are periodically sent to all authors/reviewers. - Request EMC support in driving the review of documents across the Trust.	14/10/14 - (TM) Action plan in place and being worked through to manage and assist the SLs to review their procedural documents. 29/12/14 (TM) - Outstanding number overdue down to 259 (168 clinical). Work taking place with DDs to review their divisional lists and for them to review with SLs at PRMs. Outstanding numbers now also being added to SL scorecards. SLs also being challenged over outstanding docs and asked for action plans to address them during the accreditation process. 05/03/15 (TM) - Action plan continues to be progressed. EMC now monitoring and DDs are being challenged regularly on progress. CRM meeting with DDs and Dep CEO to discuss and progress further. A simplified process has been developed to ensure all staff know what is expected of them when reviewing docs to ensure they progress and are ratified in a timely manner.

																	- Provide support and information including templates to authors and reviewers. - Set a deadline for the review of all policies/guidelines - Populate the drive to review/update all documents via Global etc	11/06/15 (TM) - Good progress being made since DoN and Med Dir reviewed the outstanding list. Some authors have become better engaged. Currently number outstanding is 218 (121 clinical). 22.10.15 (SS/DT) Intensive work has been taking place to bring all documents up-to-date. Substantial reduction in out-of-date documents is evidenced.
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	6	Treat	PTL Meeting	John Wong	14/10/2014	29/01/2016	30/12/2016 00:00:00	Safety SO1	Escalation meetings in place twice weekly. Performance monitored at PTL Meetings.	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. 13/02/15 - Reviewed by TMoore - Work continues to improve the processes and pathways. This includes: the development of the weekly PTL meeting to provide robust assessment and resolution of delays on the pathways (DL to lead), the education of service line managers on cancer related issues, to ensure that these are managed within the service line (TM to lead), the identification of improved processes between KHFT and RMH to ensure prompt transfer of information (TM to lead), the review of performance against the LCA guidelines by tumour site (Sarah Evans to lead). 12/05/15 (TM) - Intensive work continues on the management of the cancer waiting times. Weekly PTL meetings are now taking place in all tumour sites. The escalation policy has been revised and reissues. Weekly tumour site meetings have been introduced in plastics and skin. A gap analysis against the LCA guidelines has been completed for each tumour site and action shave been agreed. Work is now focusing on the development of a training package for MDT coordinators, the recruitment of 1.5 wte additional MDT coordinators, the production of a revised cancer access policy with associated training for clinical and administrative teams. 22.10.15 (NK) The additional 1.5 WTE MDT co-ordinators have now been appointed and a further 1.0 WTE has also been appointed. This has significantly help with the tracking of cancer patients. The weekly PTL meetings continue and are attended ny the service line managers and MDT co-ordinators. Patients have
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	6	Treat	Quality Improvement Working Group	Lead Resuscitation Officer / Head of Clinical Audit & Effectiveness	14/10/2014	30/01/2016	30/12/2016 00:00:00	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.	14/10/14 (TM) - Actions underway. 19/11/14 - Actions progressing, no new updates. 30/12/14 (AJ) - Actions completed apart from leaflet. Re-audit carried out and reported December 2014 – awaiting clinical view on risk rating. 13/04/15 - (AJ) - No change – we are currently awaiting analysis of last results. 19.08.15 (AJ/DT)Report showing individual Service Line data sent to Clinical Directors July 2015. Change to DNAR form on CRS awaited. CRS email link to highlight DNAR to consultant for countersignature still currently not working. Raised with CRS team. Risk remains the same. 09/12/2015 (AJ) - Recent audit results discussed at Clinical Effectiveness Committee. Risk remains the same. Further actions include email from Med Director to all Consultants, feedback from next snapshot audit in 2/52 to doctors at the time of the audit, with education, discuss at Medicine Monday meeting 14.12.15.
T048	35. Corporate Affairs	Inability to either transfer or download patient electronic medical records from CRS due to limitations of software. We have great difficultly in meeting any request for 'copies' of patients' medical records, which involve episodes of care not in paper format. Given the increasing likelihood that all patient records will be electronic, our inability to provide this information in a timely and accessible format is a risk. Such requests for information are made	Deficiency in Patient Electronic Medical Records	Strategic	Moderate 3	Almost certain 5	15	6	6	Treat	CRC & EMC	Head of Litigation, Complaints and PALS	24/08/2015	31/03/2016	30/12/2016 00:00:00	safety, Effectiveness, Responsive and Well-led.	Currently, this risk is mitigated by manually creating a set of medical records by using the crude printing function of CRS. This printing function only allows for a data dump which means that for any episode of care for a patient multiple copies of paper (for eg 700 pages) have to be put into a meaningful order before either scanning (the Coroner will only accept sectioned as per paper records, paginated and scanned electronic copies of notes) or collating. This takes significantly more time than the photocopying of paper records, and is reliant upon those doing it to understand how to sift the multiple printed pages into some sort of accessible order. It requires more senior staff time to check that it does correctly.	Risk has just been captured as progress is being monitored against Action Plan. Talking to IT about ways of getting the system changed - (i.e. trying to get the system changed). 14.12.15 (CP) CEP reviewed but no progress made as this is an IT-related risks that will only change when improvements are made on CRS.

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		by patients, families, Coroners, lawyers and others.																
T049	33. Corporate	Failure to meet registered nursing & midwifery agency reduction requirements as set out by Monitor - potential risk of regulatory action	Monitor agency guidelines - Aug 15	Financial	Moderate 3	Possible 3	9	3	6	Treat	EMC	Director of Nursing and Patient Experience	08/09/2015	31/01/2016	30/12/2016 00:00:00	Safety/ Caring/Well Led	Continue with recruitment plan as per T044 risk Undertake further international recruitment (Oct/Nov15) Review and monitor agency expenditure trajectory in line with Monitor reporting definitions & thresholds (Sept 15) Review of nursing & midwifery agency contracts completed in March 2015 Re-Issue guidance to organisation on use of framework approved agencies (Sept 15) Increase availability of bank office to drive increase in bank from agency usage (Aug 15)	Recruitment plan continues to be deployed Further international recruitment trips planned to India, Philipines & Portugal in October/November 2015 Agency expenditure trajectory completed in line with submission requirements for Monitor. To be added to Trust performance reports Guidance reissued to organisation Bank office now open later each week day and available at weekends
T050	33. Corporate	If there is non-compliance with Sepsis 6 protocol, patient safety and experience may be compromised. a) Care and treatment provided to patients who died and were coded with 'sepsis' (from Mortality Review for CQC) b) Screening for recognition of sepsis (from CQUIN audits Q1+Q2) c) Administration of antibiotics when sepsis diagnosed in A&E (from CQUIN audit Q2)	CQUIN audits of Sepsis & Sepsis mortality review	Quality	Moderate 3	Likely 4	12	3	6	Treat	Clinical Effectiveness Group	ITU Consultant and Trust Sepsis Lead (Dr. Ram Kumar)	16/11/2015	31/01/2016	30/12/2016 00:00:00	Safety and Effectiveness Strategic Objectives 1 & 2	Improvements in line with the Sepsis QIP and as provided in the Report in response to the CQC mortality outlier alert for septicaemia	
T054	33. Corporate	The potential risk of medicines being prescribed incorrectly. Medicines safety due to Errors in Prescribing. Patients may receive suboptimal care as medication might be ineffective or cause toxicity.. Patient safety and the quality of care may be compromised due to errors on prescribing.	Incident	Quality / Finance	Moderate 3	Possible 3	9	6	6	Treat	Medicines Safety Committee	Medical Director	21/12/2015	29/02/2016	16/04/2017 00:00:00	Safety, Caring, Responsive, Effectiveness & Well-led Strategic Objectives 1 & 2	- Pharmacists undertaking Level 2 Medicine Reconciliation using Summary Care Records (SCR) and Kingston Health Passport (KHP). - Daily checks on prescriptions by ward pharmacist (M-F). - Pharmacist on AAU 7/7 - Prescribing training for medical staff - Medicine Safety Audits - Medicine Safety Newsletters - Introduction of Electronic Prescribing which has some decision support	04.01.16 (DC) Medicines Safety Thermometer Audit and Pharmacy Intervention Audit have been completed in Dec, 2015.
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	4	4	Treat	Directorate of Nursing; Health & Safety Committee; Security.	Director of Estates	11/02/2014	31/03/2016	29/12/2016 00:00:00	Safety, Responsive Strategic Objective 1	- Measure for absconding patients are under review. - Policies still being prepared and ratified.	* 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. April 15 (HG) - DoH guidance still under national review. July 15 (HG) - Policy now withdrawn and policy can be completed and approved, to be completed by October 2015. October 15 (HG) Policy in draft and being circulated prior to ratification. 04.01.16 (DT) Risk reduced as policy has now ben approved.

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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	4	Treat	CIC	Director of Estates	11/02/2014	31/03/2016	30/12/2016 00:00:00	Safety, Effective and Responsive Strategic Objective 1	- 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.	Preparation of the business case is underway. 13/08/14 HG - No change 11/11/14 HG - BC is going through approval process. April 2015 (HG) - Installation phased over the next four years. August 2015 (HG) Year 1 works to be carried out in Q3. Oct 15 (HG) installation work has commenced as planned in Q3.
T046	33. Corporate	Risk to patient-quality due to non-compliance with aspects of a number of NICE guidelines which could lead to substandard patient care and reputational issues for the Trust.	Risk assessment on internal report	Quality	Minor 2	Unlikely 2	4	2	4	Treat	Clinical Effectiveness Committee	Medical Director / Head of Clinical Audit and Effectiveness	14/10/2014	29/02/2016	30/12/2016 00:00:00	Safety / Effectiveness / Caring / Responsive SO1 / SO5	Update and implement NICE development plan for 2014/15	14/10/14 (TM) - NICE development plan being reviewed. 19.08.15 (AJ/DT)The NICE Implementation Policy and development plan is currently being updated and should go to Clinical Effectiveness Committee on 14th October for approval. Currently updating the reports by Service Line. The risk rating remains the same in my view. 15.12.15 (JW) Reviewed by risk stays as the same.
T047	33. Corporate	Cancer & Palliative Care: Potential harm to patients and/or distress for families due to reduced support at weekends, low attendance of mandatory training by staff, poor documentation relating EoLC and DNAR decisions and post death support.	National Audit results leading to risk assessment	Quality	Major 4	Possible 3	12	4	4	Treat	End of Life Care Strategy Group	Consultant Palliative Care Deputy Director of Nursing	11/12/2014	31/03/2016	16/12/2016 00:00:00	Effectiveness / Caring / Responsive SO1 / SO2	National Audit Action Plan developed and progressing. Due to be completed by Summer 2015. National audit is annual.	19/12/2014 - Action plan progressing. 08.01.16 (LK) As per the report for the National Care of Dying 4 audit from 2013, the report has been updated and is available to read with actions undertaken outlined. The only outstanding items are that we still only have a 6/7 day face to face 9-5 service for the palliative care team, but we have a business case which has been agreed and logged and we are exploring funding options. Item 1 of the clinical KPI's - Care of Elderly are piloting a decision summary and a medical daily care plan for dying patients as part of a QUIP, so this is underway. Item 5 on the clinical KPI's has been re-audited and results demonstrate improvements scoring above the national audit results. There has also been a prn order set added for prn medications at the end of life recently added to CRS. All other items have been achieved
T051	33. Corporate	Central control of quality or performance management may be lost if a consistent approach to governance is not maintained within Service Lines.	Other: Risk Assessment	Quality / Strategy	Minor 2	Possible 3	6	2	4	Treat	EMC	CEO	21/12/2015	31/03/2016	30/12/2016 00:00:00	Safe, Well-led, & Effective Strategic Objective 1	• Service line management and governance structures implemented through accreditation process. • Role of the Service Line Trio. • Monitoring of quality of service line management operation through Corporate Affairs/Quality Governance teams and Compliance & Risk Committee. • Support from Corporate Risk Manager and Quality Improvement Leads for Patient Safety	
T052	33. Corporate	Sub-optimal operation may occur if relationships between Service Lines and support services fail to be effective.	Risk Assessment	Quality / Strategy	Minor 2	Possible 3	6	2	4	Treat	EMC	CEO	21/12/2015	31/03/2016	30/12/2016 00:00:00	Well-led	• Oversight through monthly divisional performance review meetings. • Opportunities for collaborative working through MDTs and joint meetings.	