Kingston Hospital
NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

Trust Board	**Item: 25**
Date: 11th July 2018	**Enclosure: U**
Purpose of the Report: To present the Board Assurance Framework for Month 2 of the current financial year and the Corporate Risk Register as at 28th June 2018.	
For: Information ☒ Assurance ☐ Discussion and input ☐ Decision/approval ☒	
Sponsor (Executive Lead):	Susan Simpson, Director of Corporate Governance
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Both attached
Legal / Regulatory / Reputation Implications:	
Link to Relevant CQC Domain: **Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒**	
Link to Relevant Corporate Objective:	All
Document Previously Considered By:	Executive Management Committee
Recommendations: The Board is asked to: a) approve the amended Corporate Objectives for 2018/19; b) note progress with strategic and corporate objectives at Month 2; c) identify where further controls or assurance may be necessary; and d) note the content of the Corporate Risk Register.	

Board Assurance Framework and Corporate Risk Register

The Corporate Objectives for 2018/19 were approved by the Board in February 2018. In developing the BAF for the current year it became apparent that the context for Strategic Objective 3 had moved on and that the BAF format did not lend itself to tracking progress for Corporate Objectives 7 and 8 as had originally been described.

Corporate Objective 7 has therefore been amended and Corporate Objective 8 divided to separate out the Acute Provider Collaborative programme of work into a new Corporate Objective 9. The original Corporate Objectives 7 and 8 are shown below. The amended Corporate Objectives and measures are shown on pages 7-10 of the BAF attached.

The Board is asked to approve the amended Corporate Objectives.

Strategic Objective 3 – To work creatively with our partners (NHS, commercial and community/voluntary) to consolidate and develop sustainable high quality care as part of a thriving health economy for the future Corporate Objective			
	Executive Lead/s	**Measures of Success**	**Timescale**
7. Work with local partners to transform care across the Kingston and Richmond sub-region	DSD/MD	• Contribution to the development of the Kingston and Richmond Local Plan • Plan developed to integrate specific care pathways across Kingston and Richmond • New integrated specific care pathways in one locality in both Kingston and Richmond implemented • Rollout plan developed to other Kingston and Richmond localities	June 2018 June 2018 December 2018 March 2019
8. Implement year 1 of the 5 year strategy	DSD	Agreed strategic priorities for year 1 delivered in line with plan.	March 2019

KINGSTON HOSPITAL NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK

Date: Month 2 2018-19

Overall progress key:			
Completed	Expected progress	Some slippage	At risk

Strategic Objective 1 - To ensure that care is rated as outstanding, as defined by the CQC across all core services by 2021/22					
	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO1: Deliver the Improvement Programme to support the transformation of patient admin	Amber	COO	Milestones delivered in line with agreed plan	March 2019	
	Amber	COO	Improvements delivered against KPIs in line with agreed trajectory	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	N/A	0	N/A

CRR (red) ref:	*CRR (amber) ref:*
Controls	Assurance that controls are effective
• Lean development programme and 'Improvement Faculty' • OPD Transformation Board (joint with CCG primary care)	• Reports to Productivity & Improvement Board and Executive Management Committee • Finance/FIP reports to FIC • Quality reports to QAC
Current gaps in controls/assurance	Commentary
• Project management support - to be addressed through restructure • Reviewing Business Information needs for transformation programmes	•

Strategic Objective 1 - To ensure that care is rated as outstanding, as defined by the CQC across all core services by 2021/22

Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO2: Deliver the Improvement Programme to support patient flow	Green	COO	**Emergency care** • Milestones delivered in line with agreed plan to improve flow on acute medical and care of the elderly wards.	March 2019	
	Green		• Improvements delivered against KPI's on all wards in line with agreed trajectory. - Increased in the number of morning discharges - Increase in the number of weekend discharges - Reduced Lengths of Stay - Reduction in the number of Red days.	March 2019	
	Amber	DSD/COO	**Planned Care** • Milestones delivered in line with agreed plan to improve theatre utilisation	March 2019	
	Amber		• Improvements delivered in line with agreed trajectory.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	N/A	1	N/A

CRR (red) ref:	*CRR (amber) ref:* 930
Controls	Assurance that controls are effective
• Emergency Care Programme Board • Workstreams, leads and projects plans in place, reporting to ECPB • Theatre Transformation Board • A&E Delivery Board (chaired by Chief Executive)	• KPIs on performance • Reports to Productivity & Improvement Board and EMC • Finance/FIP reports to FIC • Quality reports to QAC
Current gaps in controls/assurance	Commentary
• Transformation leads not in post as yet but will be recruited through restructure • Further work required to reconcile released capacity with new funded activity. • Capital solution required for relocation of some procedures from DSU to Outpatients	• Improvement projects commenced - Red2Green Days and Safer, Faster, Better • Development of the PTL taking place • MADE events have enabled detailed information on capacity gaps across the system to support a system wide response to flow. • Dedicated resource assigned to support delivery of information requirements in Q1 • Meetings held with key service lines to agree opportunity and plans for delivery. • Theatre Users Group re-established to drive improvement.

Strategic Objective 1 - To ensure that care is rated as outstanding, as defined by the CQC across all core services by 2021/22					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO3: Make progress towards CQC rating of 'Outstanding'.	Green	DoN	• Action Plans following 2017/18 inspection developed and embedded	September 2018	QAC
			• Key areas of improvement identified to enable an overall rating of Outstanding and action plan developed.	October 2018	
			• Actions to support moving towards Outstanding delivered in line with plan.	March 2019	
			• Trust prepared for Annual Inspection and approach incorporated into BAU.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	N/A	8	N/A

CRR (red) ref:	*CRR (amber) ref:* 26, 451, 981, 1062, 1068, 1070, 1071, 1073

Controls	Assurance that controls are effective	
• CQC Programme Board • Regular peer reviews with senior nurses • Performance management meetings	• Progress reports to QAC • Deep Dives/Peer Reviews/Walkabouts • PALS/complaints data • Performance scorecards, dashboards and reports • Data on incidents •	• FFT scores • Inpatient survey results • Staff survey results • Good news stories - CEO weekly letter • Internal audit and Clinical audit reports • External accreditation visits

Current gaps in controls/assurance	Commentary
•	• Awaiting outcome of CQC inspection - Unannounced Inspection 1st & 2nd May. Further Unannounced visits on 4th May & 15th May. Well Led and Use of Resources in w/b 4th June.

Strategic Objective 1 - To ensure that care is rated as outstanding, as defined by the CQC across all core services by 2021/22

Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO4: Deliver the 'must do' operational standards: • A&E • RTT • Cancer • 7 day services	Amber	COO	• Emergency standard achieved: 95% of patients who attend ED admitted/discharged within 4 hours.	March 2019	QAC
	Green		• RTT standard achieved: incomplete performance of 92%	March 2019	
	Green		• Cancer standard achieved: 85% of patients referred on a two week wait pathway receives treatment within 62 days.	March 2019	
	Green		• Length of stay reduced on inpatient adult medical wards in line with agreed trajectory.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	3	1

CRR (red) ref:	*CRR (amber) ref:* 66, 349, 883

Controls		Assurance that controls are effective	
<u>A&E</u> • Emergency Care Programme Board • A&E Delivery Board (Chief Exec chairs) • Local health economy winter plan <u>RTT</u> • Trust PTL meetings • Performance Review meetings	<u>Cancer</u> • Cancer Board • Trust PTL meetings <u>7 day services</u> • Audit of 7 day services • Business planning processes • Electronic job planning	• A&E, Cancer & RTT performance • Cancer 38 day reporting from July • Benchmarking against HES data • Stranded and super stranded patient metrics	•

Current gaps in controls/assurance	Commentary
• A significant gap in bedded neuro and specialist neuro rehabilitation.	• Strategic work via STP and KCC to address rehabilitation shortfall. • Work has commenced with NHSE re specialist neuro rehabilitiation shortfall.

Strategic Objective 2 – To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO5: Improve performance in response to staff survey	Green	DoW	Improvement delivered against KPIs: • Reducing Turnover in key service areas where it is detrimental, through innovative pay and conditions (Reduce turnover 16.5% to 15.75%)	March 2019	Workforce Committee
	Green		• Creating an integrated Faculty of Education to maximise the limited training resource to ensure all staff groups have their training needs met (increase compliance with appraisals from 88% to 90% & mandatory training from 74.2% to 85%)	March 2019	
	Green		• Health and Wellbeing measures embedded to improve the mental, Physical, financial and family health of all staff (Reduce sickness from 3.27% to 2.7% and achieve 75% of flu CQUIN)	March 2019	
	Green		• Improved levels of staff engagement to enhance staff satisfaction (staff engagement score > 3.92)	March 2019	
	Green		• Best practice recruitment practice supported by enhanced solutions for staff accommodation – locally and pan London (reduce vacancy rate from 8.8% to 6%)	March 2019	
	Green		• Support for EU staff to mitigate any harmful effects of Brexit	March 2019	
	Green		• Continued support for black, Asian and minority ethnic (BAME) staff around discrimination and bullying (improved workforce race equality standard score)	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	0	0

CRR (red) ref:	*CRR (amber) ref:*

Controls		Assurance that controls are effective	
• Pay and conditions structure • Integrated Faculty of Education • Health & Wellbeing initiatives • Support for MEGA • Health and Wellbeing Strategy • Equality & Diversity Policy	• Access to staff accommodation • Education and Training Committee • Freedom to Speak Up Guardian • Time to change pledge and work with Champions • Equality Impact Assessment Process	• Data on turnover, appraisals, mandatory training, sickness • WRES score • Staff engagement score	• FTSUG reports • OH statistics • Flu vaccine take up • Coffee & Conversations • Walkabout and Governor feedback

Current gaps in controls/assurance	Commentary
•	•

Strategic Objective 2 – To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO6: Develop the Trust as an Employer of Choice in the local health economy.	Green	DoW	Milestones delivered in line with agreed plan. • Designing new job roles to meet Health and Care Plan requirements and maintain safe staffing in scarce skill areas (reduce vacancy rate from 8.8% to 6%)	March 2019	Workforce Committee
	Green		• Innovative approaches to Flexible Working to maximise staff attraction and deployment/site utilisation (reduce turnover 16.5% to 15.75%)	March 2019	
	Green		• Redesigned pay and conditions to support recruitment and retention (staff survey response score > 52.8%)	March 2019	
	Green		• Best practice employee support, focusing on mental health to build resilience (reduce sickness from 3.27% to 2.7% and achieve 75% of flu CQUIN)	March 2019	
	Green		• Best practice integrated learning and development practices, supported by e- learning and flexible delivery models (Increase compliance with appraisals from 88% to 90% and mandatory training from 74.2% to 85%)	March 2019	
	Green		• Developing a Nursing and Midwifery Workforce Strategy.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	6	3

CRR (red) ref:	*CRR (amber) ref:* 234, 241, 245, 985, 1090, 1134
Controls	Assurance that controls are effective
• Nursing, Midwifery & AHP Board • HR policies • Freedom to Speak Up Guardian • Time to change pledge and work with Champions • Integrated Faculty of Education • Education and Training Committee • Workforce strategy • Health and Wellbeing strategy • Implementation of pan-London rates • AskHR app and centralised contact arrangements	• Safe staffing reports • Data on vacancies, turnover, appraisals, mandatory training, sickness • FTSUG reports • Flu vaccine take up • Coffee & Conversations • Walkabout and Governor feedback • Staff survey results
Current gaps in controls/assurance	Commentary
	•

Strategic Objective 3 – To work creatively with our partners (NHS, commercial and community/voluntary) to consolidate and develop sustainable high quality care as part of thriving health economy for the future.					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO7: Work with local partners to transform care across the Kingston, Richmond and East Elmbridge Sub-region.	Green	DSD/MD/ COO	• Contribution to the development of the Kingston and Richmond Local Plans	November 2018	
	Green		• Provide support to local boroughs in development of the clinical strategy	September 2018	
	Green		• Provide support to local boroughs in delivery of the clinical strategy	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	2	1

CRR (red) ref:	*CRR (amber) ref:* 967, 1017
Controls	Assurance that controls are effective
• A&E Delivery Board oversight of transformation programmes • Outpatients Transformation Board under development • Exec link to Local Transformation Board through Chief Executive	• Reports to the Board
Current gaps in controls/assurance	Commentary
• Uncertainty over route to contribution to ROBC and East Elmbridge plans	•

Strategic Objective 3 – To work creatively with our partners (NHS, commercial and community/voluntary) to consolidate and develop sustainable high quality care as part of thriving health economy for the future.					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO8: With partners develop strategy to strengthen elective services across SW London including the agreement of a strategy for QMH	Green	DSD	• Delivery of elective services review in line with agreed milestones • Contribution to the development of the strategy for QMH	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	0	0

CRR (red) ref:	*CRR (amber) ref:*
Controls	Assurance that controls are effective
• QMH Programme Board • Acute Transformation Board • SWL Programme Director in place • SWL Elective Services Review project plan	• Reports to Trust Board and EMC
Current gaps in controls/assurance	Commentary
•	•

Strategic Objective 3 – To work creatively with our partners (NHS, commercial and community/voluntary) to consolidate and develop sustainable high quality care as part of thriving health economy for the future.

Corporate Objective	Overall Progress	Exec Lead	Milestones		Target Date	Lead Committee
CO9: Deliver agreed programme of work for collaboration through the Acute Provider Collaborative 7 programmes spanning: • SWLEOC (SWL elective orthopaedic service) • SWL Pathology • Workforce (collaborative staff bank, evaluation of payroll provider options, joint training for hard to recruit to posts) • Procurement • IM&T • Radiology • Single acute medicines formulary	Amber	Chief Executive	Achieve £1m CIP for KHFT in 18/19	- Procurement £460k - SWLEOC £100k - Radiology £75k - Pharmacy £15k *Less £140k investment to deliver*	£490k to be identified by end July, key areas: - IM&T - AHP staff bank	EMC
	Green		Operational and clinical resilience	Full roll-out of collaborative staff bank Joint out-of-hours interventional radiology rota	On track against projects' milestones Q1 and Q2	
	Green		Quality improvements	- reduce prescribing errors through single medicines formulary -reduce unwarranted clinical variation through standardised electronic patient record	In development; - Collaborative capital bid for IM&T - baseline modelling for single medicines formulary	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	0	0

CRR (red) ref:	*CRR (amber) ref:*
Controls	**Assurance that controls are effective**
• Acute Provider Collaboration Board (monthly) reviews progress, issues and risks against agreed delivery plans (CEOs) • Programme plan and steering group in place for each workstream	• Reports to Trust Board and EMC
Current gaps in controls/assurance	**Commentary**
• None identified	May position reported to June Collaboration Board: • Risk regarding delivery of SWLEOC stretch targets –M1 and M2 delivery below plan for Kingston. Recovery planning in place, including options to mitigate (reduced rate of referrals). RAG has been changed to amber / yellow.

	• 18/19 APC CIP target is unchanged at £3.5m; plan currently at net CIP of £2.6m • No other programmes are behind their schedule; none are ahead • 1 yellow/ green RAG ratings (collaborative staff bank) has improved in May to green • Plan in pipeline to mitigate 18/19 investment costs (available to Trusts participating in collaborative staff bank only)

Strategic Objective 4: To deliver sustainable, well managed, value for money services.

Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO10: Finalise plan for future development of the estate.	Amber	DoF	• Outline Business Case for the future development of the Trust's estate reviewed	April 2018	FIC
	Amber		• Appropriate stakeholder engagement strategy fully developed and pursued	April 2018	
	Green		• Full Business Case and detailed design (intermediate milestones to be added) prepared.	March 2019	
	Green		• Detailed funding model developed reflecting optimised commercial arrangements with service providers (including retail, PPU and developers) and reflecting estates rationalisation plan.	March 2019	
	Green		• Financing secured for the redevelopment of the site.	March 2019	
	Green		• Risk adjusted backlog maintenance plan included with strategy, highlighting opportunities to ensure all facilities are fit for purpose and high/significant risks are addressed within a reasonable time frame.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	3	6	4	4

CRR (red) ref: 953, 925, 1027	*CRR (amber) ref:* 926, 1001, 1002, 1116
Controls	**Assurance that controls are effective**
• Engagement of specialists to support development of business cases. • Project manager engaged. • Engagement with relevant part of Department of Health to ensure our thinking is consistent with national direction of travel. • Fire Safety Programme Board overseeing delivery of 2 year capital improvement programme. • Engagement with London Fire Brigade and independent fire safety expert.	• Regular reports to the Trust Board and EMC on estates masterplan development. • Regular reports to the Trust Board and EMC on Fire Safety Programme progress.
Current gaps in controls/assurance	**Commentary**
•	• Regular estates development workshops taking place (include external contributors)

Strategic Objective 4: To deliver sustainable, well managed, value for money services.					
Corporate Objective	Overall Progress	Exec Lead	Milestones	Target Date	Lead Committee
CO11: Develop and implement plans to support short and longer term financial sustainability.	Green	DoF (DSD)	**Short term** • Delivery of agreed financial improvement plans.	March 2019	FIC
	Green		**Longer term** • 5 year sustainability plan refreshed in line with STP.	September 2018	
	Green		• Action plans developed to support longer term financial sustainability.	December 2018	
	Green		• Actions delivered in line with agreed plan.	March 2019	

Associated risks on the Corporate Risk Register (CRR)	Red Rated (this period)	Red rated (last period)	Amber rated (this period)	Amber rated (last period)
	0	0	3	4

CRR (red) ref:	*CRR (amber) ref:* 1018, 1020, 1113
Controls	Assurance that controls are effective
• Annual budget 2018/19 approved • PwC financial gap analysis • 2018/19 Financial Challenge Plan • Productivity & Improvement Board • PPU Working Group with regular updates to EMC and Trust Board	• FIP Tracking reports • Monthly report to FIC/Trust Board • Benchmarking data • Single Oversight Framework KPIs and segmentation • Regular review of the Model Hospital
Current gaps in controls/assurance	Commentary
•	•

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
1	Corporate Services	953	Estates	Risk of fire spreading because of breaches in fire compartmentation throughout Esher Wing	In a developing fire situation, premature spread of fire and/or smoke beyond compartment of origin as a result of identified breaches within fire resisting compartmentation throughout the Esher Wing building.	Internal Report	Health & Safety	5	5	25	5	20	Health & Safety Committee	Director Of Estates & Faciliti	08/11/2016	31/05/2018	13/07/2018	**1. Full building survey to be undertaken to establish status of fire resisting compartmentation.** **2. Notify London Fire Brigade (LFB) of current situation.** **3. Inform Esher Wing staff of current situation and interim Fire Action Plan.** **4. Contractor to be engaged to carryout remedial works as required. 5. Exercise/drill needed to reiterate vertical evacuation techniques.** **6. Dedicated patrolling Fire Watch to be introduced.** **7. Remedial works to protect Means of Escape.** **8. Remedial work to reinstate compartmentation between levels.** **9. Remedial work to reinstate 60 minute compartmentation between wards/departments.** **10. Remedial works to reinstate 30 minute compartmentation of hazard rooms.**	**06/18 (DL) - Work progressing as planned. Contractor has been appointed for the wards at Levels 6 and 7 and is due to commence in Cambridge ward next.** **Date Entered : 13/06/2018 15:39** **Entered By : Kate Callaghan** **----------** **04/18 (DL) - Fire stopping to the 30 & 60 minute compartment lines nearing completion at Levels 2-6 and progressing at Level 1. Outstanding 5 wards at Levels 6 & 7 to be progressed in May.** **Fire stopping to floors in the vertical risers and installation of FD 60 door sets nearing completion. Ward entrance doors at Levels 6 & 7 and those around CCU commencing in May/July. Work on fire and smoke dampers progressing whilst works to FD30 door sets is to progress as part of a separate contract.** **Date Entered : 24/04/2018 11:08** **Entered By : Kate Callaghan** **----------** **03/18 (RE) - Fire remedial works completed in Theatres 1,2,4,6,7,8. Work currently being carried out to common areas beginning with Level 5. Work within the ward areas projected to restart after winter pressures. Risk remains at current level until total evacuation protocol is removed.** **Date Entered : 07/03/2018 14:35** **Entered By : Kate Callaghan** **----------** **We are still on vertical evacuation with the fire service delivering 100% attendance. Full Executive Team oversight through Fire Safety monthly meeting. Fire Training in induction continues.** **Date Entered : 19/02/2018 10:34** **Entered By : Helen Moyles** **----------** **12/17 (RE) - Progress through Esher Wing in line with Capital Project Programme (4.4). Five wards now completed. Projected downgrading of risk (to 15) in April 2018 prior to further reduction in the summer of 2018.** **Date Entered : 08/12/2017 10:06** **Entered By : Kate Callaghan** **----------** **08/17 (SB) - Progress being made** **Date Entered : 14/08/2017 14:06** **Entered By : Kate Callaghan** **----------** **1. The survey to establish status of compartmentation has been commissioned and is due for completion on the 17th March 2017.** **2. 10/11/16 - Duncan Hodge, Inspecting Officer has been to site and advised of the current situation and mitigating actions being put in place. He will advise relevant parties of the current situation to give an appropriate understanding of evacuation, firefighting requirements, appropriate level of attendance etc.** **Regular updates given to LFB (on-going).**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
2	Corporate Services	925	Estates	Defective electrical panels on Esher Wing level 4	Defective electrical panels on Esher Wing level 4 are nearly 50 years old due to age of panels and overloading, risk of power supply failure to theater and ITU. These panels supply electrical power both mains and generated back to all of Esher Wing, i.e. main theatres and ITU.	Other	Health & Safety	5	3	15	6	15	Health & Safety Committee	Director Of Estates & Faciliti	24/02/2017	01/03/2018	27/07/2018	**Develop action plan to present to Board in order to replace the panels** **04/04/2018- Replacement plan in 17-18 Capital Plan? Generator for this area?**	**3. Global e-mails sent at regular intervals (on-going). Relevant information sent to all Matrons and ASP to give this info. at team talks/handovers.** **4. The first stage of this work was to bulkheads within hidden voids, to the 3 x service riser cupboards. This work was completed on the 9th February 2017. Work to enhance fire stopping to electrical cupboards within the North/South protected staircases started on the 20th February 2017 and was completed on the 3rd March 2017.** **5. LFB/Trust evacuation exercise using vertical evacuation was conducted on the 8th February 2017. Principal elements to this exercise were the practical use of Ski-Sheets to facilitate vertical (staircase) evacuation of dependent service users and triage in relation to evacuation requirements. A further exercise is planned for 24/05/17.** **6. Dedicated patrolling Fire Watch introduced 25/02/17.** **Date Entered : 02/05/2017 15:36** **Entered By : Kate Callaghan** **06/18 (MP) - An order has been raised and work planned to proceed on 4th August. A shutdown is required for electrical services affecting areas such as Theatres, Mortuary, Histology, Esher wing south essential electrical riser serving levels 5, 6 & 7.** **All work is under control and liaising with relevant people involved.** **Date Entered : 27/06/2018 10:47** **Entered By : Kate Callaghan** **----------** **04/18 (MP) - Switches have been ordered. Commissioning anticipated by end of May 2018.** **Date Entered : 26/04/2018 10:49** **Entered By : Kate Callaghan** **----------** **PPM -Planned Preventative Maintenance** **Date Entered : 15/02/2018 12:36** **Entered By : Helen Moyles** **----------** **04/04/2018** **Currently regular checks are carried out as part of PPM.** **Date Entered : 15/02/2018 12:35** **Entered By : Helen Moyles** **----------** **01/18 (CH) - No change** **Date Entered : 16/01/2018 15:00** **Entered By : Kate Callaghan** **----------** **11/17 (PF) - Aspirator system Quotes received**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
3	Unplanned	1027	Radiology	Risk of death / injury due to poor fire compartmentalisation & Poor fire doors. Risk of fire spread to floor above.	There has been a compromise to the fire compartmentalisation in the Department, due to works above the doors. 12 2CS 2.C01 12 2CS 2.CO2 12 2W 2.C41 l2 BASEMENT FIRE ZONE II 12 2N 2.C11 12 2N 2.106 There is a large gap or poor state of repair in door number 12 2CS 2.C01 - Large Gap 12 2.CS 2.C02- Large Gap 12 2.CS 2.C03 - Door does not close correctly 12 4N 4.118 - Door does not close correctly 12 4N 4.116 - Door does not close correctly Door from Radiology to Dental - does not close correctly 12 2W S.004 - Door does not close correctly	Review	Health & Safety	5	3	15	5	15	Clinical Governance Meeting	Manager	31/08/2017	01/06/2018	30/09/2017	**This risk was identified in the Radiology Clinical Governance Meeting.** **The notes suggested that there was a risk.**	**Date Entered : 23/11/2017 12:42** **Entered By : Kate Callaghan** **----------** **08/17 (SB) - Quote for fire alarm system received for aspirator system to be fitted in level 4 LV Switch Room, Esher Wing as per the advice of Fire Officer.** **Date Entered : 15/08/2017 14:13** **Entered By : Kate Callaghan** **This risk was reviewed in the Radiology Risk meeting (Clinical Governance Meeting) on the 16/4/18** **A 55 page report was received highlighting the poor infrastructure of the building.** **PAR will action the report** **Date Entered : 18/04/2018 16:29** **Entered By : Paul Reid** **----------** **No works as yet has started - risk to remain the same.** **Date Entered : 27/03/2018 14:18** **Entered By : Helen Moyles** **----------** **Update from EMC - works to resolve this will be completed by March 2018.** **Date Entered : 15/02/2018 11:32** **Entered By : Helen Moyles** **----------** **This risk was reviewed in the Radiology Risk meeting (Clinical Governance Meeting) on the 12/2/18** **No Change** **A separate internal audit has been arranged to re-assign the risk** **Date Entered : 14/02/2018 13:56** **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting (Clinical Governance Meeting) on the 11/12/17** **No Change** **The Radiology department has yet to receive a copy of the Hunters report.** **Date Entered : 13/12/2017 08:58** **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting on 6th November 2017 - No change.**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			Date Entered : 07/12/2017 13:44 **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting on 16th October 2017 - No change to risk - however the security grills have now been removed.** **Date Entered : 17/10/2017 14:54** **Entered By : Paul Reid** **----------** **Risk Reviewed at the Radiology Clinical Governance meeting (11/9/17) - No change.** **Date Entered : 14/09/2017 10:45** **Entered By : Paul Reid**
4	Corporate Services	1147	Estates	Risk of fire spreading because of breaches in fire compartmentation throughout DSU/Maternity	Residual inadequacies in main 60 minute compartmentation have not been addressed. Fire and smoke spread into adjacent areas.	Internal Report	Health & Safety	5	3	15	1	15	Health & Safety Committee	Director Of Estates & Faciliti	17/05/2018	18/03/2019	30/07/2018	**A fire containment mitigation project is to be undertaken.**	**06/18 (CS) - No change** **Date Entered : 25/06/2018 09:57** **Entered By : Kate Callaghan**
5	Planned	26	Oral & ENT	Risk of delayed or duplicated care due to lack of full remote IMT access at community sites	Lack of remote IMT access at six community sites where over 3000 patients are seen annually, leading to delayed patient care, duplication of care and poor patient experience. Non compliance with IQIPS standards Clinical Domain.	Incident	Quality	3	4	12	6	12	Clinical Governance Meeting	Head Of Service	07/03/2014	31/12/2018	30/04/2018	**-ensure local protocol in place** **-ensure hard copies of current protocols retained by staff** **-submit new work take on application to IMT** **-ensure remote access solution identified and introduced**	**IMT engineer allocated and liaising with Speciality Technical lead. In interim local protocol in place and hard copies of protocols retained by staff. Four recent no harm incidents relating to delayed clinic running and need to rearrange pt appointments.** **Date Entered : 21/06/2018 13:21** **Entered By : Justine Sweet** **----------** **Agreement made with Sharon Graham to include in 2018/19 IMT Capital Plan. Project representatives scoping potential options.** **Date Entered : 26/04/2018 10:11** **Entered By : Justine Sweet** **----------** **Unchanged position. Need for support/resolution on Sharon Gregory's list of requests for prioritisation in 2018/2019 IMT Plan.** **Date Entered : 27/03/2018 14:21** **Entered By : Helen Moyles** **----------** **Risk reviewed with our IMT lead and Information Asset Controller.** **The lack of IMT access for all of our community clinics is causing significant daily difficulties, affecting everyday care for every patient we see at these clinics.** **I expect this to be a mandatory finding during the forthcoming external UKAS IQIPS accreditation onsite visit planned for 4-6 April 18.** **Date Entered : 30/01/2018 08:21** **Entered By : Helen Moyles** **----------** **Project Initiation Document presented to and support by IM&T Steering Group. IM&T Project Manager allocated and completely feasability options processes with the support the Audiology IMT Lead.**

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6	Corporate Services	234	Information Services	Risk of core information not being produced due to staff with specific knowledge leave/unavailable to the Trust	Staff with specific knowledge leave/ unavailable to Trust and therefore some core information cannot be produced.	Risk Assessment	Quality	3	2	6	12	12	IM&T Steering Committee	Head Of Planning, Information	06/03/2012	09/05/2016	11/09/2018	**Ensure that procedures are documented for core information.** **Ensure that migration to automated reporting is delivered**	**Date Entered: 19/01/2018** **Entered by: Justine Sweet** **- VDI's installed in Emberbrook HC, Surbiton HC and Cobham DSU but but not functioniong reliably so IMT meeting requested.** **- VDI to be installed at Brockle Bank Health Centre. PID IMT request submitted** **Date Entered : 09/01/2018 07:50** **Entered By : Justine Sweet** **----------** **- VDI access now available at Emberbrook. IMT progressing for other sites** **Date Entered : 10/11/2017 10:14** **Entered By : Justine Sweet** **----------** **- Progressing offsite access solution with support of IMT** **Date Entered : 11/08/2017 09:21** **Entered By : Justine Sweet** **----------** **- VDI access now available at Emberbrook. IMT progressing for other sites** **Date Entered : 10/05/2017 11:26** **Entered By : Justine Sweet** **----------** **IM&T PID sumbitted and IM&T project lead working with service-line IT lead to explore solutions** **Date Entered : 22/02/2017 11:20** **Entered By : Justine Sweet** **----------** **-local protocol in place -hard copies of current protocols retained by staff -new work take on application submitted to IMT -IMT project manager scoping remote access solutions by 31 July 2014 27/06/14 - TM/FW reviewed score and reduce. June 15 and Dec 15 - reviewed by JS: - IMT scoping works on hold until 2016/2017 due to lack of funding 31 March 16 - Reviewed by JS: Need included in service-line capital plan 2016-2017 4/5/16 - JS reviewed and inreased risk following unsuccessful request for capital IMT funding in 2015/16 and need to resolve issue being highlighted during external IQIPS accreditation visit. Escalated to Associate Director 16/3/2016 - no progress. To be escalated at PRM meeting** **Procedures documented (critical) and automation stands at 20% (BI team can cope at this level. The 80% remaining is not critical). 80% work included in Data Warehouse replacement project** **Date Entered : 14/06/2018 08:24** **Entered By : Kevin Fitzgerald** **----------** **Senior Information analys has left the Organisation. Increase in projects with BI required.** **Date Entered : 10/05/2018 08:56**

Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan

Entered By : Kevin Fitzgerald

Limites progress on CIP, review at end of April

Date Entered : 08/03/2018 09:01
Entered By : Kevin Fitzgerald

Non-deliverable CIP (under discussion)

Date Entered : 08/02/2018 08:54
Entered By : Kevin Fitzgerald

No Change

Date Entered : 10/10/2017 08:00
Entered By : Kevin Fitzgerald

No change

Date Entered : 14/09/2017 08:52
Entered By : Kevin Fitzgerald

CIP requirement may lead to inability to fund posts to support both business as usual activities and NWTO. Risk likelihood increase from 2 to 4.

Date Entered : 10/08/2017 08:12
Entered By : Kevin Fitzgerald

Risk now set as "Tolerate" as all mitigations have been put in place and we are at target risk level

Date Entered : 12/04/2017 08:35
Entered By : Kevin Fitzgerald

SUS member of staff has left and there will be further gaps in staffing due to Maty leave

Date Entered : 09/02/2017 08:12
Entered By : Kevin Fitzgerald

11/01/17 reviewed, No change

Date Entered : 11/01/2017 07:52
Entered By : Kevin Fitzgerald

15/12/16 reviewed, no change

Date Entered : 15/12/2016 08:14
Entered By : Kevin Fitzgerald

Documentation review completed. All procedures have a regular review date 9/10/14

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			Reviewed - plan highly effective 19/1/15 Reviewed, no change 12/10/15 Reviewed core BAU task are completed as a priority 24/3 Reviewed, no change 28/7/15 Reviewed, 1 key staff has left, 1 resigned 21/12/15 Staffing review undertaken , proposals for restructure to promote and support increased movement of tasks to automation using SQL developed. SQL development and training plan for department commissioned. New Information Strategy underway to set 3-year plan (closely aligned to the IT Strategy). 18/1/16 reviewed 15/2 Reviewed, re-strucuture completed 14/4/16 reviewed, situation stable, out for recruitment of additional posts 14/7/16 reviewed, team is stable, but ongoing risk of key people leaving (3/4)
7	Unplanned	348	Radiology	Increasing use of diagnostics by stakeholders leading to capacity / demand / performance issues within Radiology service	Increasing use of diagnostics by stakeholders leading to capacity / demand / performance issues within Radiology service	Workforce Report	Quality/Finance	3	4	12	6	12	Clinical Governance Meeting	Service Line Manager	01/07/2014	31/03/2016	16/01/2018	**Future imaging needs to be integral part of 5 year strategy.** **Demand management within high use areas.** **Increased use of PTL in all modalities.**	**This risk was reviewed in the Radiology Risk meeting (Clinical Governance Meeting) on the 16/4/18** **increased as the workload has increased across many specialties and modalities including Breast, CT, MRI & GP referrals** **Date Entered : 18/04/2018 16:32** **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting (Clinical Governance Meeting) on the 12/2/18** **No Change** **Date Entered : 14/02/2018 13:51** **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting on 6th November 2017 - No change.** **Date Entered : 07/12/2017 13:36** **Entered By : Paul Reid** **----------** **This risk was reviewed in the Radiology Risk meeting on 16th October 2017 - No change.** **Date Entered : 17/10/2017 14:48** **Entered By : Paul Reid** **----------** **Risk Reviewed at the Radiology Clinical Governance meeting (11/9/17) - downgraded to 2 x 3** **Date Entered : 14/09/2017 10:37** **Entered By : Paul Reid** **----------** **Risk Reviewed at the Radiology Clinical Governance meeting (14/8/17) - No change until the new MRI phase takes place** **Date Entered : 15/08/2017 11:10** **Entered By : Paul Reid** **----------** **With the start of the Cancer Vanguard the radiology staff have had to alter their**

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																			working patterns so as to be able to accommodate the Blue Dot / two week rule patients **Discussed at the RGM 19/12/16 No Change** **Date Entered : 19/12/2016 12:58** **Entered By : Alison Tuck** **Discussed at the RGM 14/11/16 - no changes to be made** **Date Entered : 18/11/2016 15:49** **Entered By : Alison Tuck** **Discussed at RGM** **No actions required** **Date Entered : 28/09/2016 13:16** **Entered By : Alison Tuck** **Discussed at the RGM 27/7/16** **No changes** **Date Entered : 01/09/2016 10:24** **Entered By : Alison Tuck** **Discussed at RGM on 27/7/15 - There has been a rise of 21% in MRI and 14% in CT this financial year against the plan projection of 6-10%. áMobile scanners and outsourcing to Epsom has been arranged for August AJTáDiscussed at RGM on 26/10/15 Chest and Abdomen Reporting course is in the process of being set up for Radiographers to increase skill mix within the department and allow for better use of Radiologists time AJT. Radiographer Reporting Courses confirmed for March 2016 (3 staff). JW**
8	Unplanned	883	Gastroenterology And Endoscopy	Risk of failure of paper based booking and referral system in endoscopy	Risk of failing to respond in a timely way to requests for an endoscopy procedure. Risk to patient care if department does not receive the correct clinical information from referrer. Risk if failing to meet key access targets - cancer and diagnostic targets Division will be unable to deliver the cancer targets in time required without moving the whole booking system electronic. This means the department needs CRE templates to book directly into.	Complaint	Quality	4	3	12	8	12	Risk Management Group	Service Manager	30/09/2016	31/12/2018	31/07/2018	**04/04/2018-** **Electronic referral system now being designed in CRS due to do the 1st environment.** **Investment from department in expansion of current cancer tracker package info flex with the purchase of scheduling and referral package** **change all endoscopy referrals to an electronic pathway** **Next steps:** **Put EMS business case paper on the agenda for emergency care board** **Chase change team for new date** **Inform Cancer pathway and surgery that new STT pathway wont go live until a new date is set for electronica referral.**	**Current Mitigation is being applied. Department is manually reviewing all referrals and rejecting any that are incomplete.** **New STT nurse led triage pathway will also support further mitigation until the new electronic referral card is engaged .** **Date Entered : 02/05/2018 14:56** **Entered By : Avishkar Hiraman** **----------** **Division is still waiting timelines for electronic referral to go live. Date of 19th March was missed and currently change team have not fedback on new date.** **Division is unable to sustain artificial safeguarding currently in place as clearly seen by our rising incident rate. Since Jan 2018 --74 incidents are clocked against Endoscopy admin alone.** **Paper based system is not sustainable** **Wider endoscopy management system is also required to streamline and safeguard as electronic referral alone will not reduce incident rate.** **Division has :-**

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over 6000 day referrals and a further 1000 in Emergencies referrals. Add in the timeframe needed to be booked 5- 10 days the whole endoscopy system requires wider investment and needs an endoscopy management system to move away from Paper diaries, Paper referrals, DSU letters that cannot be altered to match out booking outline and need to be manually written with time and date.

Next steps:

Put EMS business case paper on the agenda for emergency care board
Chase change team for new date
Inform Cancer pathway and surgery that new STT pathway wont go live until a new date is set for electronica referral.

Date Entered : 29/03/2018 14:28
Entered By : Helen Moyles

Still no response from the change team around when electronic referral will be ready, Chased Shaun Kidd awaiting response.

Date Entered : 29/01/2018 08:43
Entered By : Joanna Gardner

Currently reviewing options to build out referral forms on Cerner, concerns are the length of time this is taking and lack of feedback on the overall timelines.

division cannot maintain quantity of referrals that are sent in daily which manually need to be inputted everyday into Cerner as activity grows.

The division also needs to have CRS templates drawn up for booking directly into cerner to remove the paper based booking system currently in place.

Division wont be able to offer the new STT colon pathway under faster diagnosis unless we move the whole booking system electronic.

Date Entered : 29/11/2017 09:28
Entered By : Joanna Gardner

Project has now moved to option 3 in which the e-referral will be undertaken by CRS and the booking will continue on CRS as well.

Awaiting to move onto test phase with referral.

Date Entered : 25/05/2017 09:06
Entered By : Joanna Gardner

7.3.2017

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			A workshop to explore project options took place mid-Jan, Conclusions from that workshop have been incorporated into a project exception paper (also attached and for discussion within a project board). **Recommendations** **12) In order to most quickly satisfy JAG reporting requirements and to remove the most risky element of the existing Endoscopy workflow, the Project Board is invited to consider when and how resource can be provided to achieve Phases 1 and 2 as a priority.** **13) The objective of Phase 3 is to remove the necessity for Endoscopy to manually key referral details to CRS; additionally Phase 3 was to enable appointments to be booked for correct durations automatically (based on the referred procedures).** **It is now known these objectives cannot be met by any currently understood design; also that analysis of the various alternative options (and associated compromises) will not be quickly understood.** **This paper seeks agreement that Endoscopy must accept keying referral details (as first captured by referring consultants) to CRS in order that appointments are booked and managed on CRS - and that this position is enduring until a revised proposal can be described, costed, and receives formal approval.** **Further discussion is required about if CRS now build out the referral form and Infoflex is simply for scheduling.** **Next meeting to be confirmed.**
9	Unplanned	245	Accident & Emergency	MIDDLE GRADE RECURITMENT: Unable to recruit and retain A&E middle grade doctors leading to gaps within the rota, risking optimum paitient care as shortfall in substantive middle gardes to deliver timley, effective and high quality care	Unable to recruit and retain A&E middle grade doctors leading to gaps within the rota, risking optimum paitient care as shortfall in substantive middle gardes to deliver timley, effective and high quality care	Risk Assessment	Quality	4	3	12	4	12	Workforce Committee	Clinical Director	01/06/2012	31/12/2018	18/06/2018	**1. Establish sufficient Emergency Medicine Consultant presence in the ED 16 hours a day, 7 days a week as a minimum** **2. Develop an A&E Staffing Strategy** **3. Gap analysis against College of Medicine Standards demonstrates that 16 consultants are recommended (currently budgeted for 10 WTE)** **4. Ensure timely recruitment of vacant posts.**	**Date Entered : 07/03/2017 10:35** **Entered By : Joanna Gardner** **- Conitnual review of rotas skill mix and undergoign demand and capacity work mapping staffing against attendnaces and performance across the day and week** **- Innovative roles to mitigate against vacancies such as ACPs and Resus team continue to be embedded within the department** **- Rolling adverts out for ST3+, Specialty Doctor, CESR Rotational** **- Medical Workforce finalising agreement and terms with Agency to facilitate Overseas Recruitment** **- 1 new appointment at Middle grade level and 2 at JCF/SHO level** **Date Entered : 02/05/2018 17:20** **Entered By : Caroline Moulton** **----------** **Middle Grade Staffing remains a challenge in ED** **- A specific recruitment strategy is being developed with Medical HR Team and recruitment. This includes a targeted campaign for middle grades, using social media, overseas recruitment and national / international conference stands.** **- Since January 2018 changes to the medical rota have converted a middle grade lines to a Junior Clinical Fellow which are likely to have more successful recruitment.** **- Additional mitigation includes the new Resus Team of Band 6 and 7 nurses and**

Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																		Paramedics and the additional ACP and trainee ACP's in the UTC which all started in post in January 2018, providing enhanced support and skills to these areas of the ED **Date Entered : 31/01/2018 12:17** **Entered By : Caroline Moulton** **----------** **Staffing challenges continue, rota's continue to be reviewed - alternative roles being explored to mitigate vacanices at middle grade. Active recruitment continues with offers made to candidates.** **Date Entered : 06/12/2017 12:22** **Entered By : Helen Moyles** **----------** **JULY 2017:** **Staffing challenges continue at this Tier. Mitigating plan includes:** **- All roles currently being advised, with enhancements to current offers (F2 / Regs / Consultants)** **- Rate comparison undertaken and benchmarked against other EDs / specialties to ensure parity.** **- Regular contact with Bank Partners Team to mobilise team.** **- Discussions ongoing via Emergency Care Programme Board for further strategies to mitigate impact. This includes ways to enhance current offer, including rotational programmes etc.** **- Practitioner recruitment also in progress.** **AE Staffing Strategy implemented and being regularly reviewed and checked.** **Date Entered : 18/07/2017 12:03** **Entered By : Tom Hastings** **----------** **IR35 regulation has impacted significantly on ability to fill rota gaps. Escalation to Executive Team, NHS Improvement and other partners underway. 3 x rounds of MG interviews taken place. 3 x offers in process for Specialty Doctors. Escalated rates agreed for Consultant / SHO to mitigate and all partner agencies (e.g. GPs / Nurse Practitioner Agencies) being mobilised. Extra nursing shifts being rostered, where felt necessary, to promote patient safety.** **Date Entered : 02/05/2017 18:20** **Entered By : Tom Hastings** **----------** **Middle Grade adverts all being promoted; article in BMJ. Interview date set up for 1 x Specialty Doctor and 1 x MG. Revised Workforce Model currently with executive team for sign off. Work ongoing with Bank Partners to bring in Doctors on lines of the rota to help with staffing risk. Mitigation of risk currently also includes additional Consultant working and further recruitment for ANP / ENP and EP roles.** **Date Entered : 13/03/2017 11:59** **Entered By : Helen Moyles** **----------**

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10	Corporate Services	451	Corporate	Risk of failure to identify patients with sepsis and treat them in line with the Sepsis 6 protocol may lead to longer length of hospital stay and suboptimal outcomes including increased morbidity and possibly mortality.	Failure to identify patients with sepsis and treat them in line with the Sepsis 6 protocol may lead suboptimal outcome.	External Report	Quality	3	4	12	6	12	Executive Management Committee	Trust Sepsis Lead	16/11/2015	30/12/2016	06/03/2018	**1. Improvements in line with the Sepsis QI project, currently in its 2nd year** **2. Audit for CQUIN for in-patients** **3. Sepsis Steering group to review actions**	**Further round of recruitment - closed early November. 1 applicant offered at CT1 level. Next round of recruitment sent out by HR immediately after advert closed. To shortlist applicants.** **New workforce model being developed as part of ECPB.** **Other roles recruited into as a mitigation - including Emergency Practitioner, extended GP cover to 18 hours per day and ESPs working in department. Weekly review of MG staffing position.** **Date Entered : 30/11/2016 15:26** **Entered By : Tom Hastings** **----------** **Score increased to reflect this.** **Date Entered : 24/11/2016 14:11** **Entered By : Helen Moyles** **----------** **Numbers of leavers at this tier which means that the department is finding it increasingly difficult to deliver full cover 7/7, particularly delivering two registrars at night. The service continues to have high usage of locum and agency staff.** **Recent recruitment at this tier (two round with the last nine months) has led to limited appointments to fill leavers.** **Date Entered : 24/11/2016 14:10** **Entered By : Helen Moyles** **----------** **New version created as risk reworded.** **Date Entered : 26/10/2016 11:40** **Entered By : Helen Moyles** **New Sepsis Nurse appointed and started 04/12/2017. Risk to be reviewed in 2 x months to reassess score as may reduce to a 3x3=9. Sepsis CQUIN requirements met for Q1, not met for Q2 and partially met for Q3** **Date Entered : 06/12/2017 15:20** **Entered By : Alison Vizulis** **----------** **Risk likelihood score to be increased from 3 to 4 - CRR Data cleansing meeting of 10/08/2017** **Date Entered : 04/10/2017 10:55** **Entered By : Saba Anjum** **----------** **Risk remains the same - ongoing monitoring** **Date Entered : 20/03/2017 09:57** **Entered By : Helen Moyles** **----------** **Improvements in screening and antibiotic administrations for A&E, audit now started.**

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11	Corporate Services	926	Estates	No UPS/IPS installed for electrical sockets in theatres 1-8	There is no UPS/IPS installed for electrical sockets in Esher theatres 1-8. During generator testing the sockets in theatres will lose power for a few seconds during changeover. As a result, in a worst case scenario, if we were to lose generator backup power and mains we would have no power within these theatres.	Other	Health & Safety	5	3	15	8	12	Health & Safety Committee	Director Of Estates & Faciliti	28/02/2017	29/09/2017	27/07/2018	**To get quotes for a new UPS/IPS system and present a strategy for installation the Board.**	**Date Entered : 17/11/2016 13:12** **Entered By : Helen Moyles** **06/18 (MP) - A survey has been done by BENDER to install UPS/IPS in all theatres which has 2 systems and levels priced.** **There will be added cost to take those services down into theatre with additional dedicated distribution board, trunking and sockets install needed.** **A business case will be required to proceed with the work.** **Date Entered : 27/06/2018 11:06** **Entered By : Kate Callaghan** **----------** **04/18 (SA) - Batteries for the UPS system have been ordered** **Date Entered : 24/04/2018 12:31** **Entered By : Kate Callaghan** **----------** **01/18 (CH) - £50K assigned in the 2018/19 budget** **Date Entered : 16/01/2018 15:07** **Entered By : Kate Callaghan** **----------** **11/17 (PF) - No progress** **Date Entered : 23/11/2017 12:48** **Entered By : Kate Callaghan** **----------** **08/17 (PF) - A quote has been received and a business plan presented to Capital Projects** **Date Entered : 14/08/2017 15:13** **Entered By : Kate Callaghan**
12	Planned	985	Paediatrics & NNU	Reduced number of allocated paediatric registrar's from the Deanery therefore in order to maintain a 10 person registrar rota to run safe and sustainable Paediatric and Neonatal service within the trust, regular locum doctors are required to cover the rota. There is a risk that the paediatric registrar locum shifts are not covered by Bank Partners.	Reduced number of allocated paediatric registrar's from the Deanery therefore in order to maintain a 10 person registrar rota to run safe and sustainable Paediatric and Neonatal service within the trust, regular locum doctors are required to cover the rota. There is a risk that the paediatric registrar locum shifts are not covered by Bank Partners.	Other	Quality/Finance	4	3	12	8	12	Performance Review Meeting	Clinical Director	07/06/2017	01/01/2019	18/07/2018	**-Eight person Paediatric registrar rota has been implemented to cover the Paediatric and Neonatal service.** **-Consultants to cover the twice weekly rapid access clinics instead of the registrar's** **-Medical rota co-coordinator to liaise closely with 'Bank Partners' to ensure that registrar locum shifts are filled well in advance and all shifts out to all medical agencies.** **-Medical rota co-ordinator to be able to fill the shifts directly with our regular bank Paediatric registrars or medical agencies and inform 'Bank Partners' of the shifts filled.**	**Business case for 5 resident consultant has been approved and awaiting for approval of JD's and then the posts will go out to advert.** **Date Entered : 18/06/2018 13:59** **Entered By : Sarah Shade** **----------** **Risk reviewed and remains the same.** **Date Entered : 24/05/2018 15:59** **Entered By : Sarah Shade** **----------** **Risk reviewed and remains the same.** **04/04/2018** **Agreement to recruit additional consultants** **Date Entered : 27/03/2018 14:54** **Entered By : Helen Moyles** **----------**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
13	Corporate Services	1001	IM&T	Risk of failure of unavailability of IT systems due to uninterrupted power supply (UPS) failure in main computer room.	UPS out of warranty, parts no longer available, maintenance of a best efforts basis.	Business Case	Quality/Finance	3	4	12	3	12	IM&T Steering Committee	Director Of IM&T	01/08/2017	31/12/2018	19/04/2018	**Replace switch gear and UPS in room** **KHFT to sign contract (Procurement)**	**Spoke to the CD Dr Filkin and Service line manager Asha Patel and there is no change to this risk, current score risk of 12 remains the same.** **Date Entered : 19/01/2018 16:34** **Entered By : Sarah Shade** **----------** **No change to this risk; continue to run a 8 registrar rota. SS** **Date Entered : 10/10/2017 10:38** **Entered By : Sarah Shade** **Still awaiting timescale for construction work to commence to build housing for Chillers** **Date Entered : 23/03/2018 15:53** **Entered By : Kevin Fitzgerald** **Work confirmed for 23rd March to replace power supply** **Date Entered : 23/03/2018 15:51** **Entered By : Kevin Fitzgerald** **----------** **Planned for 23rd March** **Date Entered : 12/03/2018 16:15** **Entered By : Kevin Fitzgerald** **----------** **Power supply replacement now planned for 12th March.** **Date Entered : 14/02/2018 12:33** **Entered By : Kevin Fitzgerald** **----------** **Power supply replacement has been discussed between Estates and Contractor - lilkely to be completed by end of Feb '18** **Date Entered : 16/01/2018 10:18** **Entered By : Kevin Fitzgerald** **----------** **Order has been placed - timescale for implementation TBC** **Date Entered : 13/11/2017 09:24** **Entered By : Kevin Fitzgerald** **Concern over ongoing delays for the Main computer room power supply replacement (althought draft plans now in place).** **Review again in one month when firmer timescales should be available** **Date Entered : 10/10/2017 07:21** **Entered By : Kevin Fitzgerald**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
14	Corporate Services	1002	IM&T	Risk of temperature being outside of safe parameters for the electrical operation of the main computer room due to inadequate air flow due to the air conditioning system being obsolete.	Air conditioning system obsolete and out-of-warranty, parts no longer available	Business Case	Quality/Finance	3	3	9	6	12	IM&T Steering Committee	Director Of IM&T	01/08/2017	31/12/2018	30/07/2018	**Build A/C on roof and commission** **Replacement of air conditioning.**	**A/C due to be installed on roof 14th July** **Date Entered : 25/06/2018 15:24** **Entered By : Kevin Fitzgerald** **----------** **No Change - timescales remain June/July '18** **Date Entered : 12/03/2018 16:14** **Entered By : Kevin Fitzgerald** **----------** **Medical records store construction** **Date Entered : 15/02/2018 10:11** **Entered By : Helen Moyles** **No Change - timescales remain the same, but options to implement some a/c are being investigated.** **Date Entered : 16/01/2018 10:20** **Entered By : Kevin Fitzgerald** **----------** **Latest estimate is that Medical Records store will not be ready until June/July '18** **Date Entered : 13/11/2017 09:25** **Entered By : Kevin Fitzgerald** **----------** **No date available - review again in one moth when timescales should be available** **Date Entered : 10/10/2017 07:22** **Entered By : Kevin Fitzgerald**
15	Corporate Services	1017	Finance	Local services in their current form and in the current funding regime may be neither affordable or finacially sustainable.	Failure to close the affordability gap locally and remove stranded costs may result in financial tensions in local health economy. Affordability gaps included within 2017/18 commissioner contracts may result in reduction to contract income and therefore impact on service delivery and sustainability.	Review	Financial/Strategy	4	4	16	9	12	Finance & Investment Committee	Director Of Finance	31/07/2017	31/03/2018	30/04/2018	**We continue to work closely with local commissioners to ensure that the financial risk within the system if appropriately managed and the quality and safety of the service delivered by the Trust is not compromised.** **NHSI are aware of our financial position and we have recently reforecast our year end outturn position for 2017/18. In light of the Trust's current financial position we are also in receipt of funding support which goes some way to mitigate the risk that financial pressure may otherwise bring to bare on the services the Trust delivers.** **We are also in the process of business planning and budget setting for 2018/19 with regular touch points with Commissioners, Regulators, the Board, and staff. A draft of the plan is due to be produced for 8th March with a final version of the plan for 2018/19 signed off 30 April 2018.**	**Progress to be monitored at EMC, FIC and the Board.** **Date Entered : 14/02/2018 13:41** **Entered By : Jo Farrar**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
16	Corporate Services	1018	Finance	Non delivery of CIP targets or other elements of the financial plan	Non delivery of CIP targets, underachievement if income, or greater than envisaged levels of expenditure leading to Trust not meeting financial plans.	Other	Quality/Finance	4	3	12	6	12	Finance & Investment Committee	Director Of Finance	31/07/2017	31/03/2018	08/11/2017	**We routinely review the Trust's current and prospective financial position as part of the monthly reporting cycle at performance meetings, EMC, FIC and the Board. Recovery actions where required and appropriate, always with reference to the quality and safety of services, are also tracked at these forums. The CCGs and NHSI are also kept appraised of our financial position to ensure that funds are available to mitigate the risk of the financial position compromising our ability to deliver services.**	
17	Corporate Services	1020	Finance	Failure to meet financial control total requirements on both financial and performance targets may also result in a loss of STF income which will adversley impact on liquidity.	We continue to work closely with local commissioners to ensure that the financial risk within the system if appropriately managed and the quality and safety of the service delivered by the Trust is not compromised. NHSI are aware of our financial position and we have recently reforecast our year end outturn position for 2017/18. In light of the Trust's current financial position we are also in receipt of funding support which goes some way to mitigate the risk that financial pressure may otherwise bring to bare on the services the Trust delivers. We are in regular contact with NHSI, DH and the lead CCG to ensure that we have an approirate line of credit to ensure that liquidity issues do not compromise our ability to deliver services.	Other	Quality/Finance	4	4	16	6	12	Finance & Investment Committee	Deputy Director Of Finance	31/07/2017	31/03/2018	31/03/2017		
18	Unplanned	1062	Cardiology & Haematology	Risk to patient safety when blood results not made available to anti coagulation team.	Risk to patient safety due to those patients', whose blood specimen is taken in primary care, results not being provided to anti coagulation team from SWLP via the DAWN system.	Incident	Quality	4	3	12	4	12	Clinical Governance Meeting	Clinical Risk Lead	25/09/2017	31/07/2018	01/06/2018	**1. Issue escalated to SWLP via Dr Atwal who is member of SWLP Governance board. Jim Weir, Acting AD, and J Oliver, SWLP Operational Lead, also aware. 2. We have requested that all low and high INR results be highlighted to anti coagulation team at KHFT. 3. Safeguarding meeting with external partners has included discussion about this issue and a first meeting of the multi agency task and finish group has been held to review the risk across primary and secondary care. 4. Improved access for District Nursing teams to KHFT clinical team implemented 5. Revised information on blood request forms**	**Safeguarding has now closed - risk has been mitigated as much as is possible. District Nursing teams have improved access to clinical team at KHFT. Revision of information on blood request form from community has improved situation for those patients being seen by District Nurses. Continue with plan. Risk remains. Date Entered : 02/05/2018 11:58 Entered By : Maxine Gates ---------- Risk has been escalated to SWLP. All low and high INR results will be highlighted to team. Safeguarding meeting with external partners has taken place. Date Entered : 15/02/2018 10:32 Entered By : Helen Moyles**
19	Planned	1068	Ophthalmology	Risk to patient safety/experience due to minimal access to IT at Hawks Road Community Clinic	Outpatient clinics at Hawks Road Community Clinic are being run without continuous access to IT and CRS, which may lead to patient safety issues due to loss of data and registration	Change In Service	Quality	3	4	12	3	12	Clinical Governance Meeting	Clinical Lead	28/11/2017	30/06/2018	25/05/2018	**Manual record of patient attendance and request. Inputted onto CRS at the REU by admin team the following day. Meeting between KHFT and Your Healthcare IT has taken place to identify the IT issues and present solution**	**1. Access to CRS has improved overall. Individual clinicians continue to have a problem and the REU team are liaising with Your Healthcare team to solve this. Date Entered : 08/06/2018 10:47 Entered By : Julie Habbin ---------- 1. Your Healthcare have downloaded the updated drivers on one PC and the access**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
20	Planned	1070	Ophthalmology	Risk of patient harm due to patients retinal appointments not being offered as per treatment pathway which may result loss of visual acuity	Risk of poor patient experience and care due to lack of appropriate capacity to meet demand in the retinal service	Incident	Quality	3	4	12	6	12	Clinical Governance Meeting	Clinical Director	28/11/2017	31/12/2018	25/05/2018	**Additional medical retinal consultant post being advertised in December 2017. Currently being covered by a locum** **Close monitoring of request lists** **OCT clinics at Raynes Park Health Centre and remote review by consultant to increase capacity** **Review of current clinics and capacity to identify where they can be increased**	**to CRS has improved. Plan to update all existing PC's and need to buy new PC's not required. 2. There are still ongoing IT issues which are causing problems - Your Healthcare are working to solve these - until these are solved access to CRS is limited** **Date Entered : 02/05/2018 10:48** **Entered By : Julie Habbin** **----------** **1. Discussions are still ongoing with Your Healthcare and KHFT IT. The proposal is to buy new PC's and download updated drivers. The PC's would also be used by other non KHFT users. Possible to trial one new PC and download updated drivers on one PC. KCCG are also supporting finding a solution** **Date Entered : 26/03/2018 09:59** **Entered By : Julie Habbin** **----------** **1. Your Healthcare advised that new PC's required. One has been ordered to trial if it improves the CRS functionality** **2. One clinic template has been reduced due to impact of poor IT** **Date Entered : 14/02/2018 13:04** **Entered By : Julie Habbin** **----------** **Risk remains as there has not been any improvement. Discussions taking place.** **Date Entered : 14/12/2017 14:30** **Entered By : Julie Habbin** **1. New retinal fellow started on the 14th May 18. New text service not in place and awaiting an update of when this will go live. All follow up patients are receiving a reminder phone call. Locum still in place to continue work on the follow up waiting list** **Date Entered : 08/06/2018 10:51** **Entered By : Julie Habbin** **----------** **1. New substantive consultant started on the 1st April 18. 2 Replacement retinal fellow appointed - start date expected to be June 18 2. High number of retinal follow up DNA's - as well as the current reminder text an additional text will be introduced in June which will be sent at 5 to 6 weeks and remind patients who have had long standing appointments as this group tend to be higher DNA'ers. All follow up patients to also receive a telephone reminder from the REU** **Date Entered : 02/05/2018 10:52** **Entered By : Julie Habbin** **----------** **1. Locum consultant continuing until MR fellow starts** **Date Entered : 26/03/2018 10:10** **Entered By : Julie Habbin** **----------** **1. Substantive consultant starting 1st April 2018.**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			2. Advert for retinal fellow closing on the 26th March 18 and interviews planned for the 11th April 18 (to replace fellow who has been appointed as consultant). **3. Cleansing of request list to be completed by 6th April 2018** **4. Head orthoptist working with medical retinal consultants to maximize the MR optometrist clinic templates** **Date Entered : 26/03/2018 10:09** **Entered By : Julie Habbin** **----------** **1.Substantive medical retina consultant appointed. Start date to be confirmed.** **2. Retinal request list being cleaned and then for micro management via the daily performance meeting** **3. OCT clinics at RPHC in place** **4. MR optometrist templates under review** **5. Weekly retinal meeting identifying different ways of working** **Date Entered : 14/02/2018 13:12** **Entered By : Julie Habbin** **----------** **Risk reviewed.** **Date Entered : 14/12/2017 15:11** **Entered By : Helen Moyles**
21	Planned	1071	Ophthalmology	Risk of patient harm due to Patients AMD appointments not being offered as per treatment pathway which may result loss of visual acuity	Risk of visual deterioration in patients with AMD due to insufficient capacity to see patients at the correct timely intervals	Incident	Quality	3	4	12	3	12	Clinical Governance Meeting	Clinical Director	28/11/2017	31/12/2018	25/05/2018	**Additional medical retinal consultant being advertised December 2017** **Four additional Saturday clinics per month to provide extra capacity** **Additional nurse injectors being trained to provide more injection lists** **Review of templates for optometrists to consider increasing to provide more capacity** **Close monitoring of request list by AMD PPC**	**New retinal fellow started on the 14th May 18. Once monthly extra clinics run on a Saturday. Investigating the opportunity to run extra injection lists during the week** **Date Entered : 08/06/2018 10:52** **Entered By : Julie Habbin** **----------** **1. Substantive MR consultant started on the 1st April 18. 2. Replacement MR fellow appointed and is expected to start in June 18. 3. AMD patients closely monitored and extra injection clinics arranged as required. 4. Once monthly Saturday clinics run if extra capacity required. 5. Additional nurse injector being trained** **Date Entered : 02/05/2018 10:55** **Entered By : Julie Habbin** **----------** **1. Medical retinal consultant staring 1st April 2018.** **2. Replacement fellow post advert closes 26th March 2018 and the interviews are planned for the 11th April 2018.** **3. Once monthly Saturday clinics are being run and forward planned to manage capacity** **4. Nurse injector to be signed off by end of April 18. Additional nurse to start training** **5. Head Orthoptist working with consultants to review optometrist templates** **6. Plan to start see and treat clinics at RPHC once cleared by infecton control** **Date Entered : 26/03/2018 10:14** **Entered By : Julie Habbin** **----------** **1. Substantive medical retina consultant appointed. Start date TBC.**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			2. Additional Saturday clinics running as required **3. Further nurse injector will be signed off end of Feb 18** **4. Optometrist templates are being reviewed** **Date Entered : 14/02/2018 13:15** **Entered By : Julie Habbin** **----------** **Risk reviewed.** **Date Entered : 14/12/2017 15:21** **Entered By : Helen Moyles**
22	Planned	1073	Ophthalmology	Risk to patient experience due to lack of ophthalmology specific electronic patient records	Notes not being available for clinic or theatre procedures with the potential of having to cancel patients at short notice. Lack of e prescribing - potential increase in medication errors. Unable to carry ophthalmic specific audits recommended by the Royal College of Ophthalmologists	Incident	Quality/Finance	3	3	9	3	12	Clinical Governance Meeting	Clinical Director	28/11/2017	31/12/2018	25/05/2018	**Ophthalmology EPR on the IT list for 18/19 as a potential project** **Further development of Medisoft which is currently being used for cataracts** **Medication errors discussed a the clinical governance meetings** **Independent audit of AMD service currently underway** **Regular meeting with Health Records management team to identify issues and solution**	**Still awaiting update re. the Cerner development** **Date Entered : 08/06/2018 10:56** **Entered By : Julie Habbin** **----------** **Cerner are developing an ophthalmology specific patient record software. The REU have been put forward as a trial partner and await to see if accepted** **Date Entered : 02/05/2018 11:00** **Entered By : Julie Habbin** **----------** **1. Consultant (Mr Elgohary) to be a representative at the Trust IT group** **2. One of the trainees to undertake an audit on how many notes missing and what happened to the patient** **Date Entered : 26/03/2018 10:22** **Entered By : Julie Habbin** **----------** **1. No further progress** **Date Entered : 14/02/2018 13:21** **Entered By : Julie Habbin** **----------** **Risk reviewed.** **Date Entered : 14/12/2017 15:27** **Entered By : Helen Moyles**
23	Unplanned	1090	OPD	Risk to patient safety in clinic with the use of Bank staff to cover clinics in MOPD.	A high number of additional clinics and an increase number of permanent clinics without an increasing in MOPD substantive staff has resulted in the department relying on using Bank staff. The Bank staff are not skilled or trained to cover many of the clinics that require 1:1 support in MOPD which is resulting in a difficulty in covering clinics with the required skills.	External Report	Health & Safety	3	4	12	3	12	Risk Management Group	Matron	30/01/2018	31/05/2018	30/04/2018	**For service lines to complete the capacity and demand to enable them to request permanent clinics to reduce the need to additional clinics.** **To work out required staffing levels based on current activity.** **To meet with Finance and AD's to share required staffing and explain risk.**	**Risk reviewed following inaugural Clinical Governance meeting on the 19/3/18 by Paul Reid & Mandy Ross.** **Mathematical error corrected Wording in risk adjusted to reflect current risk.** **There is a large increase in demand for MOPD without relevant trained staff being employed.** **Date Entered : 05/04/2018 15:42** **Entered By : Paul Reid** **----------** **The Risk was reviewed in the new Clinical Governance meeting on the 19th of March**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
																			No change **Date Entered : 26/03/2018 12:18** **Entered By : Paul Reid**
24	Corporate Services	1113	Corporate	Financial risk of not achieving STF money if the ED trajectory is not met	Workstreams implemented through Emergency Care Programme Board. This is a whole system delivery plan monitored through the A&E Delivery Board.	Review	Financial	4	4	16	8	12	Risk Management Group	Associate Director	14/02/2018	14/02/2019	20/05/2018	**Workstreams implemented through Emergency Care Programme Board. This is a whole system delivery plan monitored through the A&E Delivery Board.**	**Surge plan recently reviewed and refined against the back drop of increased and sustained demand to be more responsive and action focused.** **Date Entered : 19/02/2018 14:39** **Entered By : Helen Moyles**
25	Unplanned	1116	Gastroenterology And Endoscopy	Recurring break down of near -obsolete Decontamination washers within the Endoscopy Department	Failure of equipment can lead to cancellation of lists or possible risk of infection. Decontamination kit replacement missed off trust capital planning. Replacement plan for decon machines required, needs to be undertaken by AP (Rob Kingston) Risk of infection due to age of machines - department will experience increased costs with increased contracts and more expensive filters now needing to be purchased to minimize risk of infection Decontamination manager's role is now too large to properly cover previous post - holders duties within endoscopy decontamination.	Incident	Health & Safety	4	4	16	8	12	Finance & Investment Committee	Service Line Manager	28/02/2018	28/05/2019	01/06/2018	**04/04/2018- Await further feedback after department audit. Audit undertaken to assess scale of risk and possible solutions Very positive feedback received with an outline recommendations: -** **Trust to commit to ensure that this department remains open.** **Trust to embark on An EWD Replacement Programme.** **Decontamination Quality Management System to be implemented in accordance with the MHRA Top Ten Tips.** **Decontamination Quality Management System to be registered with a Notified Body (similar to that of the SSD).** **Trust to determine and clarify who the "Official User" for this department is and in turn provide suitable support and resources.** **Item to be added back on to capital plan** **Business case to be drawn up re purchase of new equipment** **Estates to set up PO for Bob Kingston (Authorised Person)** **Specification for new washers and RO plant to be drawn up by Bob Kingston** **Go through tender process** **Increase contracts to cover the increased maintenance while we await outcome of business case**	**Although there have not been any instances of patient infection, there remains a risk that the negative results will throw up a problem. Discussed with Dr Demertzi and have agreed that the likelihood score can be dropped to 3 - making the risk 12 (TM)** **Date Entered : 04/05/2018 11:10** **Entered By : Helen Moyles** **----------** **Current mitigation continues :** **All contracts are upgraded** **Moved back to using Wassenburg filters for machines** **Removed all on site water testing** **Implemented escalation process as outlined by the AP** **Daily huddles with the decontamination technicians** **Organised all engineers to come onsite for group discussion** **Clarification on roles involved within unit and wider committee** **All required data when requested sent to the infection control team to review** **Chemical flush on both WES machines and Wassenburg machines.** **Wider business case continues to be reviewed in SSD wider evaluation around potential outsourcing.** **Authored Person Bob Kingston is booked and undertaking an evaluation of complete refurbishment of decon unit.** **Refurbishment outline and future allocation has also been incorporated into the endoscopy new build business paper for discussion as to possible options.** **Date Entered : 02/05/2018 15:22** **Entered By : Avishkar Hiraman** **----------** **Division was asked to wait unitl SSD plan has been reviewed. Unit has received no furthr feedback. Unsure what long term plan is for replacement of machines that have reached end of life.** **Date Entered : 27/03/2018 14:16**

	Service Line	Risk Ref	Specialty	Summary	Description	Source of Risk	Type	C	L	Inital Risk	Target Risk	Current Risk	Monitoring	Risk Owner	Start Date	Target Date	Review Date	Mitigations & Action Plan	Progress against Action Plan
26	Unplanned	1130	OPD	Risk of fire due to the lack of plug sockets present in the dressing room resulting in an extension lead being used to plug the fridges in.	A double socket was not put in under the counter in the dressing room when the refurbishment took place. As a result an extension lead is plugged in above the counter and training below to enable two fridges to plug in. The extension lead given to MOPD by the estates team is not long enough to lie flush on the floor and the wire could trip up staff and patients.	Internal Report	Health & Safety	4	3	12	4	12	Goverance Group	Project Manager	26/04/2018	31/05/2018	25/07/2018	**For estates to arrange for a double plug socket to be installed.**	**Entered By : Helen Moyles** **Email sent to Tom Middleton and Angela Clarks in estates highlighting the fact that this risk was raised to them on the 14th March and has not been resolved.** **Date Entered : 26/04/2018 16:33** **Entered By : Amanda Ross**
27	Unplanned	1134	Acute Assessment Unit	Risk to patient care due to not being able to meet minimum staffing requirements	Quality and consistency of care provided on AAU with not being able to meet minimum staffing requirements.	Other	Quality	3	4	12	6	12	Quality Assurance Committee	Lead Nurse Manager	03/05/2018	31/12/2018	02/06/2018	**Establishment Review** **Staff Recruitment plan** **Constant local review of skill mix and acuity for appropriate allocation of care** **Trustwide and recruitment retention project**	**Actions progressing and being monitored at the Safe Staffing Group.** **Date Entered : 03/05/2018 20:37** **Entered By : Helen Moyles**
28	Corporate Services	1145	Information Services	PTL - Business Intelligence support	PTL development and support provided by one member of staff, Risk around absence/unavailbility	Other	Quality/Finance	4	3	12	8	12	IM&T Steering Committee	Operational Lead	08/01/2018	29/10/2018	14/07/2018	**Business case for investment and recruitment for Band 7 post**	**Business case in draft (v0.1)** **Date Entered : 14/06/2018 08:34** **Entered By : Kevin Fitzgerald**
29	Corporate Services	1146	Information Services	PTL - Availability	Unavailbility of PTL to support operational performance	Other	Quality/Finance	4	3	12	8	12	IM&T Steering Committee	Operational Lead	14/06/2018	29/10/2018	14/07/2018	**Develop Business case for PTL**	**Business Case Draft (v0.1)** **Date Entered : 14/06/2018 08:48** **Entered By : Kevin Fitzgerald**
30	Corporate Services	1154	Estates	There is a risk that the public do not support the proposed development of site.	There is a risk that the public react negatively to news of the proposed development, resulting in project delays or failure, reputational and/or financial damage to the Trust.	Internal Report	Financial/Strategy	4	3	12	8	12	Finance & Investment Committee	Director Of Estates & Faciliti	21/05/2018	20/05/2019	30/07/2018	**To undertake a controlled release of information and structured communications with key stakeholders e.g. local councillors, residents, patients and staff.**	**06/18 (CS) - No change** **Date Entered : 25/06/2018 10:03** **Entered By : Kate Callaghan**