Kingston Hospital NHS
NHS Foundation Trust

Corporate Risk Register

Trust Board Meeting - Part 1	**Item: 9.2**
27th November 2013	**Enclosure: O**
Purpose of the Report: To update the Board on the contents of the Corporate Risk Register as it stands at 11th November 2013	
FOR: Information ☐ Assurance ☐ Discussion and input ☒ Decision/approval ☒	
Sponsor (Executive Lead):	Kate Grimes, Chief Executive
Author:	Jacky Bush, Head of Quality & Risk Assurance Tam Moorcroft, Corporate Risk Manager
Author Contact Details:	jacky.bush@kingstonhospital.nhs.uk 020 8546 7711 Ext 3846
Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Risks on the Corporate Risk Register are mapped to the BAF
Legal / Regulatory / Reputation Implications:	Outlines risks to statutory compliances and Indicates any areas of statutory non-compliance
Link to Relevant Corporate Objective:	Identified on the Register
Document Previously Considered By:	Compliance and Risk Committee Working Group Compliance and Risk Committee
Recommendation & Action required by the Trust Board The Trust Board is asked to **consider** the contents of the Corporate Risk Register as it stands at 11th November 2013, and **confirm** that the register provides assurance that appropriate action is being taken and that there is appropriate identification of key risks	

RISK REGISTER REPORT

Corporate Risk Register

1. The Corporate Risk Register is regularly reviewed and updated to ensure robust capture of strategic risks, as well as operational risks. Up until 31 October 2013, it was reviewed monthly at the Risk Management Committee and the Governance Planning Group. Following the introduction of the new Governance structure in November 2013, the responsibility for reviewing the Corporate Risk Register moved to the Compliance and Risk Committee and its working group. The new Clinical Quality improvement Committee, with maintain an oversight of the Quality Risks. The quality risks are reviewed at the Quality Assurance Committee (bi-monthly), with the whole risk register being reviewed at the Audit Committee.

2. The Corporate Risk Register (appendix 1) is presented to the Trust Board quarterly and was last presented in July 2013. Appendix 2 provides an overview of the Risk Register on one page.

3. The Corporate Risk Register reflects all those risks with a current score of 8 or above contained in the Board Assurance Framework, the Integrated Business Plan (IBP), Corporate Departments and Divisional Risk Registers, as well as those risks identified by the Executive Team, Risk sub committees and through the Foundation Trust work stream. Risks are added to the Corporate Risk Register following completion of a risk assessment.

4. The Corporate Risk Register records the actions planned to mitigate each risk and progress in achieving these. It supports a 'bottom up, top down' approach to the treatment of significant risks.

Key points

5. Before any Divisional risk is escalated to, or de-escalated from, the Corporate Risk Register, the escalation/de-escalation is approved by the Divisional Risk Boards and agreed by the Risk Management Committee, this process will be adapted following the recent move to Service Lines.

6. Where new or existing risks have been identified within a Specialty or Division that relate to a risk already recorded on the Corporate Risk Register these are not duplicated, but referenced in the Corporate Risk risk description, for example risk reference T021, encompasses the various risks identified within Divisions with regard to incomplete or unavailable health records, the reference numbers of the supporting risks are noted in the description.

7. To help the Board understand the risk scoring parameters the full risk matrix has been included in this report at appendix 3.

Areas of movement in the Corporate Risk Register since July 2013

8. There are five risks on the Corporate Risk Register where, since it was last presented to the Board in July 2013 the current risk score changed as a result of reassessments.

Division	Ref	Risk Description	Comments	Previous Score	New Score
Corporate	T029	Substantial Financial Penalties and risk to monitor governance risk rating as a result of exceeding the national trajectory for C.Diff. (£40,000 for every case over the 2013/14 trajectory of 15)	The risk was reviewed and the likelihood increased due to the certainty that the trajectory will be exceeded.	12	15

Division	Ref	Risk Description	Comments	Previous Score	New Score
Corporate	T028	The failure to control the occurrence of C.Diff resulting in poor outcomes and experience for our patients	The risk was reviewed and the score increased due to the increased number of cases.	8	12
Estates	T_EST005	Management of legionella and water: potential in water systems for debris from corroded pipework and risk of legionella bacteria.	The risk was reviewed and reduced because the program for replacing pipework is underway.	12	8
Corporate Services	T_IM&T013	CRS UPGRADE – USER – Staff do not consistently comply with using the system.	The risk score was reduced due to the delay of the medicines rollout.	16	9
Emergency Services Elderly Care	T_MAE_AM021	Risk of not being able to provide staff to support to those patients requiring help to eat and drink at meal times and to optimise their nutritional intake.	This risk has been reworded and re-assessed	12	8

9. Eight risks (shown below) have been escalated to the Corporate Risk Register either from Divisional Risk Registers or newly identified corporate risks (where risks have scored as 8 and above).

Division	Service Line	Ref	Description	Score
Corporate Services	Information Governance	T_IG005	Risk of ICO fines through data breaches e.g. handover sheets not being properly disposed of, emails being sent to incorrect destinations	12
Corporate		T018	Risk that handover of care to Out Of Hours (OOH) teams and provision of care at nights and weekends could compromise the ability to deliver the same quality of care as during normal working hours.	12
Corporate	Transition to Service Line Management	T032	SLM Transition -Establishing Devolved Structure. Transition to SLM could lead to reduction in control (e.g. performance / finance) and other priorities getting pushed back. This is exacerbated by the fast pace.	12
		T033	SLM Transition - Skills Development. Risk that the staff (Managers and Clinicians) do not have the skills and time to support SLM during the transition'	9
		T035	SLM Transition - Interrelationship. Risks that the service lines, corporate services and supporting IT do not move at the same pace. Risk that SL inter-relationships stay under-developed for too long. Risk that the pace of SL development is too slow	8

Division	Service Line	Ref	Description	Score
		T036	Risk to the Trust's reputation if the Friends & Family Test inpatient scores remain nationally in the bottom quartile	12
Specialist Services	Maternity	WCH_MAT 010	Financial impact under new maternity tariff caused by recharging process. The pathway tariff is paid to one provider and will be the first provider where the patient first books. There are currently no robust systems for checking if patients have booked in another unit other than asking patients and we have evidence that patients do not always admit that they are double booked. This could result in a significant financial impact if unable to recharge other units.	9
Corporate Services	Estates & Facilities	T-EST008	Esher Wing windows are distorted and overall are beyond their useful life. This materially affects the environment for patients in the wards in winter	12

10. Four risks have been re-assessed and rescored at below 8. These risks and scores were reviewed at the Governance Planning Group / Compliance and Risk Committee working group and agreed at the Risk Management Committee / Compliance and Risk Committee and therefore have been de-escalated from the Corporate Risk Register, these are:

Division	Area	Ref	Description	Comment
Specialist Services	Maternity	T_WCH_ MAT009	Commissioners may not fully fund new maternity pathways resulting in significant reduction to income. The division will be required to reduce the current service provided to woman and in particular to the antenatal and post natal care pathways reducing scanning and consultation capacity.	The risk was reviewed and deemed no longer relevant so was closed.
Specialist Services	Paediatrics	T_WCH_P AE001	Security of the Paediatric Wards and OPD - staff security against violence, abuse and theft of property, children wandering off unaccompanied, taking of young children without permission, failure to prevent unwanted visitors and no method of recording access	The risk has been mitigated as the introduction and implementation of swipe cards has been completed. The risk has been closed.
Corporate Services	IM&T	T_IMT012	'CRS UPGRADE - PATIENT SAFETY - Deployment approach means double-running for systems (electronic and paper). Patient flow crosses both systems and up-to-date information not available to staff'.	The risk score has been reduced to 4 and closed due to the delay of the medicines roll out.

Corporate Services	IM&T	T_IMT011	'CRS UPGRADE - TRAINING - Staff not trained effectively and unable to use the new system in a competent way'.	The risk score has been reduced to 6 because of the effect of the rollout on only a few areas within the Trust.

Status of Risk Registers

11. The Risk Management Committee reviewed Surgery & Critical Care Risk Register at its August 2013 meeting. The Corporate Services Risk Registers were reviewed at the September 2013 meeting; these included the risk registers from Information Governance, IM&T, Information Services and Finance. The Committee agreed that the Human Resources Risk Register was to be reviewed at the October 2013 meeting (which did take place) and the Estates Risk Register at the December 2013 meeting. Also during the October 2013 meeting the Women & Children's Service Risk Register was reviewed and the new Transition to Service Line Management Risk Register. The Committee noted that all risks had been recently reviewed and updated by the relevant Divisional Risk Boards.

Future management, reviewing and reporting of the Corporate Risk Register

12. Due to the organisational and governance committee changes in the Trust the way risk is managed within the Divisions and now Service Lines will be changing. The way in which risk is identified and assessed will essentially remain the same although the route in which risks are escalated onto the Corporate Risk Register is likely to change. The Trust's Risk Management Strategy is currently undergoing a review to reflect these changes to ensure that robust risk management remains integral to the organisation.

13. The reviewed Risk Management Strategy will be presented to the Trust Board in January 2014 for ratification.

Governance changes

14. The Risk Management Committee has now disbanded and the new Compliance & Risk Committee and its working group will be reviewing the risk registers. The Service Line Risk Registers will be reviewed by the Service Line Performance Review Meetings.

15. The timetable for the Compliance and Risk Committee review of all the risk registers is yet to be determined and will be finalised once the new Service Lines and their Risk Registers are implemented.

16. The Corporate Risk Register will be presented to the Compliance and Risk committee every month.

Recommendations:

17. The Trust Board is asked to:

1) Consider the contents of the Corporate Risk Register as it stands at 11th November 2013 and confirm that the register provides assurance that appropriate action is being taken and that there is appropriate identification of key risks.

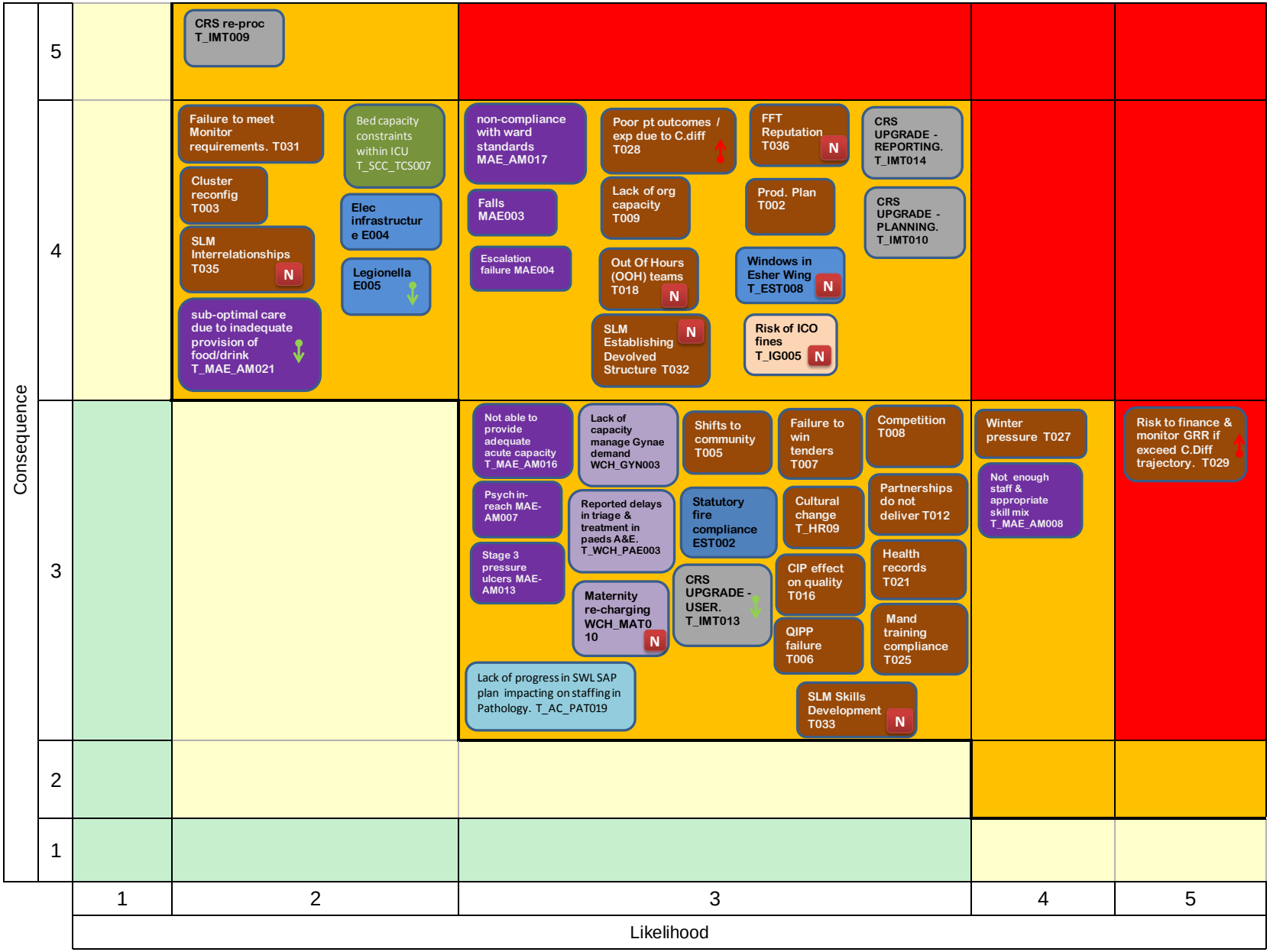
Appendix 2
Risks on one page

Corporate Risk Register - risks on 1 page

November 2013.

Key: =increased risk =decreased risk N =new risk NL =new risk linked

Info Gov | Amb Care | Corporate | IMT | Women & Child | MED | SCC | Estates



Risks reassessed as below 8 and de-esclated from the Corporate Risk Register

- Paed security WCH_PAE001
- Commissioners may not fully fund new maternity pathways WCH_MAT009
- CRS UPGRADE - TRAINING. T_IMT011
- CRS UPGRADE - PATIENT SAFETY - double-running for systems. T_IMT012

Risk Grading/rating

The grading of risk is dependent on 2 factors; the **severity/Consequences** of the hazard and the **likelihood** the hazard will occur.

Table 1 Consequence/Severity scores

Choose the most appropriate domain for the identified risk from the left hand side of the table, then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	• Overall treatment or service suboptimal • Formal complaint (stage 1) • Local resolution • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness • Formal complaint (stage 2) complaint • Local resolution (with potential to go to independent review) • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted on • Inquest/ombudsman inquiry • Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory/ key training	• Non-delivery of key objective/service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	• Breech of statutory legislation • Reduced performance rating if unresolved	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action • Multiple breeches in statutory duty • Improvement notices • Low performance rating • Critical report	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Zero performance rating • Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	• Local media coverage – • short-term reduction in public confidence • Elements of public expectation not being met	• Local media coverage – • long-term reduction in public confidence	• National media coverage with <3 days service well below reasonable public expectation	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Finance including claims	Small loss Risk of claim remote	• Loss of 0.1–0.25 per cent of budget • Claim less than £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time	• Non-delivery of key objective/ Loss of >1 per cent of budget • Failure to meet specification/ slippage • Loss of contract / payment by results • Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	• Loss/interruption of >8 hours • Minor impact on environment	• Loss/interruption of >1 day • Moderate impact on environment	• Loss/interruption of >1 week • Major impact on environment	• Permanent loss of service or facility • Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

			Likelihood				
			1	**2**	**3**	**4**	**5**
Consequence			**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5	**Catastrophic**		5	10	15	20	25
4	**Major**		4	8	12	16	20
3	**Moderate**		3	6	9	12	15
2	**Minor**		2	4	6	8	10
1	**Negligible**		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Corporate Risk Risk Register as 11th November 2013

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	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
Risk Register																	
T029	33. Corporate	Substantial Financial Penalties and risk to monitor governance risk rating as a result of exceeding the national trajectory for C.Diff. (£40,000 for every case over the 2013/14 trajectory of 15)	Infection control - incidents	Financial	Moderate 3	Almost certain 5	15	3	15	Treat	EMC	Director of Nursing and Patient Experience	06/12/2012	28/11/2013	Outcome 8 Principal Risk / BAF 1, 2, 8 Strategic Obj. 1	Implementation of peer review action plan eg: • Cleaning standards and enhanced cleaning. • Awareness raising • Revise policies Divisional ownership and accountability to EMC Divisional Monitoring of compliance with: • equipment cleaning • antibiotic policy • isolation and early stool sampling (patients admitted with diarrhoea) • Weekly Hand hygiene Audits • External review to take place November 2013	Majority of the peer review action plan have been completed: • Cleaning standards and enhanced cleaning has been implemented • Awareness raising: through Trust Board, FFF, team Brief, CEO meeting, Trust Management Forum, EMC and Grand Round. Weekly Hand hygiene audits are discussed at sisters meetings with any actions to be implemented. Consultant lead RCA Audit of compliance with Antimicrobial Policy Discussion with commissioners taking place to review framework of penalties to mitigate risk of reduction in staff and /or other service provision that would be needed to fund penalties. • External reviewer for November 2013 identified
T002	33. Corporate	Failure to deliver the Trusts long term productivity programme Linked to GS004	Business and Service Delivery Plans	Strategic	Major 4	Possible 3	12	9	12	Treat	FIC and Board AC	Productivity Director	01/04/2012	31/03/2014	CQC Outcome 26 Principal Risk 8 Priority Obj. 2 Strategic Obj 5	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.	CIPs finalised as part of 2014/15 budget setting and were presented to Trust Dev Forum 22/4/13. Monitoring process under review. Monthly Productivity Programme Boards held to date and quality impact of productivity programme monitored at QAC. New Dashboard developed to bring together financial and quality KPIs. Under performing schemes in year replaced by newly developed schemes.

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
T_MAE003	29. Acute medicine & A&E	Risk of falls resulting in harm for specific highly vulnerable patients Linked to ED012 and AM001	Risk Assessment	Quality	Major 4	Possible 3	12	8	12	Treat	Divisional risk Board	Divisonal Manager Divisional Director	27/03/2013	24/12/2013	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	1. Development and introduction of a Falls Care Bundle 2. Action Plans to be presented at the sisters meeting to share learning and also at the Divisional Risk Board. 3. Falls to be monitored on the Nursing Scorecard 4. Audits in progress of documentation and assessment processes Risk Reviewed 23/08/12- Final version of the Falls care bundle at the printers Pilot to start when final document received from the printers – no date available as yet Falls SI action plans reviewed on 21/08/12 by C Pullen, T Day and J Hickman. Action plans updated and RAG rated. 14/11/12 SP Fall Care Bundle has now been printed and final version of pilot will be implemented on 1/11/12. To be audited in 6 months time. 01/03/2013 Audit inpatient falls and post falls bundle which showed good compliance on the falls but not on post falls. Focus now on post falls with introduction of Ulyssys reporting. Matron, HoN reviewing immediately any fall to ensure documents completed. Falls group relaunched and led by DoN. 03/05/13 SE Next falls audit is scheduled for Jun/Jul 2013 and there has been 5% reduction in PSI fallsin 2012-13 as compared to 2011-12. Falls bundle fully implemented and staff training completed. Incident reporting indicatesthat staff awareness and management of falls has improved. AAU now part of falls group. 30/10/2013 SE Falls risk assessments to be carried out for all adult 65+ years of patients.
T009	33. Corporate	Risk that the Trust lacks the organisational capacity to deliver the large number of change programmes required.	Risk Assessment	Strategic	Moderate 3	Likely 4	12	6	12	Treat	AC	Director of Workforce & OD	27/12/2011	30/01/2014	Stategic Obj 2 CQC Outcome 14 Principal Risk 5 Priority Obj. 3	Development of an OD programme for 2013/14. Bottom up approach to developing CIPs over a 5 year period. Refresh underway as part of business planning for 14/15. Multi Disciplinary Groups overseeing large cross-cutting schemes. Budgets and plans for 2013/14 finalised clarifying expectations and capacity required.	OD programme approved by Trust Board. Programmes being monitored by EMC. CRS planning complete but implementation delayed. Pathology (SWLP) approved. Leadership development partner appointed. Business planning process for 2014/15 simplified

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
T_MAE004	29. Acute medicine & A&E	Failure to escalate abnormal observations resulting in poor clinical outcome. Linked to MAE_ED009 & MAE_AM005	Risk Assessment	Quality	Moderate 3	Likely 4	12	6	12	Treat	Divisional Risk Board	DM, Speciality Leads and HoNs	19/04/2013	24/12/2013	CQC outcome 4 Principal Risk 1 Strategic Obj. 1	1. Audit of Practice carried out by Practice Development team. 2. Formulation of an action plan 3. Ward sisters to undertake daily spot checks on all observations charts and this practice to be incorporated into the bedside handover procedures between shifts. 4. To undertake focused training on the wards to ensure staff are competent to assess and record observations and are fully conversant with the escalation process 5. To roll out NEWS.	All staff have received additional training through cohort and focus days Risk reviewed 23/08/12 - Re-audit of compliance of observation charts scheduled for November 2012. Also to get feed back from GTT as escalation of observations is one of the triggers JHi and LH to create risk for junior doctors and risk of non-escalation of abnormal physiology Reviewed at the DRB 29th June 2012 Audit results improving 91% April, 96% May Current risk score to remain at curent level until reaudited 14/11/12 SP Observation and escalation has been re-audited. Performance has improved. To continue monitoring. 03/05/13 SE NEWS and Vital signs charts currently being piloted with a view to roll out across the Trust. This will require close monitoring as it is a significant change in practice. Audits undertaken in April 13 showed significant improvement in the completion of vital signs monitoring. 30/10/2013 SE On ward rounds, a daily handover and observation charts are being monitored and in case of any abnormality, incident are reported.
T018	33. Corporate	Risk that handover of care to Out Of Hours (OOH) teams and provision of care at nights and weekends could compromise the ability to deliver the same quality of care as during normal working hours. Risk reworded October 2013 LINK: MAE_AM002: SP_001	Incidents / risk assessments	Quality	Major 4	Possible 3	12	6	12	Treat	Trust Steering Group QAC	Medical Director	01/01/2012	20/12/2013	Objective 1 CQC 16	Programme of work led by the Medical Director to address is underway. Work streams in Medicine and Surgery are in place to consider extended consultant days, weekend ward rounds, weekend diagnostics and further development of the Hospital at Night team. This is a Quality Account priority and will be monitored through that work stream Head of Nursing action plan Nursing review Emergency Standards action plan	Trust Steering Group to monitor workstream progress in place, work plan agreed and in progress. 10/13; risk re-worded and score increased

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
T027	33. Corporate	Impact of Winter pressures on Trust ability to maintain operational performance during winter months	Risk Assessment	Strategic	Moderate 3	Likely 4	12	6	12	Treat	EMC	COO	04/12/2012	29/11/2013	Principal Risk 1 & 2	Urgent Care Board set up across Health economy to develop winter plan.	07/13; First meeting has taken place. Baseline data is being reused. Work streams are under development. 10/13; 2013/14 winter plan now agreed. To be shared across organisation 30/10/2013 SE Winter plan for KHT has been agreed at EMC and is now being implemenetd. Sub groups of the urgennt care board have been established to im prove cross-organisational working over winter e.g. DETOC subgroup. Kingston partner organisations are meeting fortnightly to discuss winter pressures.
T_EST008	22. Estates	Esher Wing windows are distorted and overall are beyond their useful life. This materially affects the environment for patients in the wards in winter.		Quality	Major 4	Possible 3	12	4	12	Treat	Health & Safety Committee	Director of Estates and Facilities	21/10/2013	21/03/2014	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Investment is needed to replace the windows and associated fenestration. The replacement programme is being developed as part of the Estates Strategy..	For this winter, new curtains and additional heaters are being sourced.
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	12	Treat	EMC	Director of Nursing & Patient experience	06/12/2012	31/12/2013	Outcome 8 Principal Risk /BAF 1, 2, 8 Strategic Obj. 1	Implementation of peer review action plan: o Implementation of 2007 cleaning standards o Information and education for staff on stool sample collection and patient isolation sent via team Brief, global email, pop ups and letter sent with payslips o Stool charts revised o Divisional ownership and accountability to EMC and DRB o Consultant and ward sister ownership of PIR process o Antibiotic policy reviewed o Antibiotic prescribing audited monthly o Increase antimicrobial pharmacist hours o Quarterly audit of adherence to isolation and PPE policies o Quarterly audit of time taken to isolate patients with diarrhoea • Divisional monitoring of compliance with: • equipment cleaning • adherence to antibiotic policy • isolation and early stool sampling (patients admitted with diarrhoea) • monthly hand hygiene audits	Most action points within the peer review action plan have been completed or are in progress. Internal Audit of compliance with antimicrobial policy to take place, Complete additional actions in response to PIR's to ensure embedding of antibiotic practice and timely collection of stool specifmens required. 11/13 External review of process is to take place by NHSE on 5/12/13. An action plan will be created to strengthen existing processes from the findings/recommendations.

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
T_IG005	25. Information Governance	Risk of ICO fines through data breaches e.g handover sheets not being properly disposed of, emails being sent to incorrect destinations		Financial	Major 4	Possible 3	12	4	12	Treat	Information Governance Committee	Finance Director	06/03/2012	30/12/2013	Objective 5	Actions from Sis being followed. Increase IG Training take up. BI not to put PID in emails. Briefing to be taken to Div Mgs Training Plan	Note: Initially scored 8 however due to recent SI, this was increased to 12. 11/13 - Score to remain as 12.
T_MAE_AM017	12. Acute Medicine	Risk of non compliance with ward standards, as detailed in the ward scorecard, arising from ineffective (Nursing) ward leadership adversley effective patient safety	Risk Assessment	Quality	Major 4	Possible 3	12	4	12	Treat	Divisional risk board	Head of nursing, acute medicine	24/01/2013	24/12/2013	CQC outcome 4 & 13 Principal Risk 1, 2 & 5 Priority Obj. 3 Strategic Obj. 1 & 2	1. Allocate matron to supervise the work of each ward 2. Continued attendance of the Band 7 Ward Sisters on the Leadership Program. 3. Continue recruitment into the Band 6 posts and pilot short shifts on Kennet Ward.	5/03/13 JE Designated ward shifts rostering matrons and HON to lead by example. Pilot shorter shifts & implement smaller wards. Currently good progress in Blyth and Hamble where action plans including the appointment of a new charge nurse have been implemented. 03/05/2013 SE Band 7 leadership programme commenced in April 2013. All medical wards Sisters attending. Pilot on short shifts due to commence on Kennet Ward in July 2013. Band 6 recruitment in progress so that all Medical wards will have a Band 6 nurse on duty 24 hours a day. 26/06/2103 SE Discussed at triemvarate board on the 7th June. Kennet ward pilot commencing in July 2013. Cathy Pullen to present to Divisional Risk Board criteria against which the success to the pilot is measured. 30/10/2013 SE A review of all medical wards is being undertaken and an action plan has been developed. A medical wards group has been established and chaired by CEO and including Director of Nursing and Divisional Director. A leadership program for the ward sistets has been developed and is being implemented. A weekly performance score card for the wards has been developed. This and existing KPIs will be used to measure improvements.
T_IMT014	21. IM&T	CRS UPGRADE - REPORTING - statutory reporting does not work, mandatory data returns not available, or incorrect/incomplete. Operational services are impacted by not having performance data or 18week pathways are affected.	Risk Assessment	Quality	Major 4	Possible 3	12	4	12	Treat	IM&T Steering Committee (& London Cerner CE Forum and London Cerner CIO forum) AC	Head of Information Services	16/05/2013	08/11/2013	Outcome 21 Principal Risk /BAF 4 Priority Obj. 1	Reporting will be thoroughly tested prior to the implementation - 30/5/13	Testing currently underway Testing continues and report criteria has been agreed PTL being tested, continued improvement being made Testing completed Following go-live reporting has been an issue (SUS and PTL) due to data issues within the system.

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T032	33. Corporate	Establishing Devolved Structure Transition to SLM could lead to reduction in control (eg. performance / finance) and other priorities getting pushed back. This is exacerbated by the fast pace Link to SLM009,SLM011, SLM010 and SLM012	GPG / EMC risk assessment Consultation document	Quality / Finance	Major 4	Possible 3	12	4	12	Treat	EMC	CEO	13/09/2013	31/10/2013		Recruitment to posts happening quickly. Training programme being devised and rolled out. Deployment of new governance structure. COO / DoF still reviewing performance Ensure knowledge and expertese not lost within Trust	Recruitment underway. Some aspects of new governance structure in place. Trainees identified and dates set for budget training.
T_IMT010	21. IM&T	CRS UPGRADE - PLANNING - deployment might highlight issues with existing processes. Mapping from existing processes to the "to be" state may expose problems.	Risk Assessment	Quality	Major 4	Possible 3	12	4	12	Treat	IM&T Steering Committee (& London Cerner CE Forum and London Cerner CIO forum) AC	Chief Operating Officer	16/05/2013	25/10/2013	Outcome 21 Principal Risk /BAF 4 Priority Obj. 1	Document the "as is" and " to be" processes - 10/12 Undertake analysis to determine the change actions required to support the "to be" processes - TBA Implement the change actions - TBA	"As is" and "to be" processes agreed. Change action planning underway work on prescribing ongoing and change actions being monitored Change actions reviewed - further work required Following A&E and PAS go-live lessons learned information is being compiled to ensure that any future deployments build in better understanding of process uptake an compliance from staff.

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T_MAE_AM008	12. Acute Medicine	Risk of not having enough staff and appropriate skill mix to deliver high quality care.	Risk Assessment	Quality	Moderate 3	Likely 4	12	3	12	Treat	Divisional Board Meeting QAC	Head of Nursing, Medicine	05/04/2012	24/12/2013	CQC outcome 13 Principal Risk 1, 2 & 5 Priority Obj. 3 Strategic Obj. 1 & 2	Establishment review undertaken and implementation plan developed Review test applicants sit Revise drug test	Implementation of the supervisory Sister in place and 65:35 ratio implemented at night. 65:35 ratio in the day to be implemented on recruitment of Irish nurses into existing vacancies. 13/12/12 reviewed at risk Board Risk reviewed 23/08/12 - Weekly meeting now in place with HoN, Matrons and Hr to monitor recruitment progress and deal promptly with any post interview delays. Current position 7 post offered to candidates, adverts out for remaining posts Reviewed at the DRB 28/06/12 Recruitment continues Next set of applicants to pilot reviewed tests 5/12/12 JE In October 28 band 5 nurses recruited leaving 12 vacancies. Advert out for Hamble and Hardy with a a plan there after for recruitment of nurses for Kennet keats and Blyth. Discussed at DRB 24/1/2013 succesfull recruitment campaign but still have 18 vacancies and adverts continue. 5/3/13 JE Successful recruitment has not been offset due to high turnover of staff and an increase in escalation beds. 03/06/13 SE Robust recruitment campaign led by DoN now in place. A significant number of posts have been offered and are awaiting start date. 26/06/2013 SE Discussed at triemvarate board on 7th June. 41 posts offered, 17 above establishment to support CRS backfill and short shift trial on Kennet ward. 30/10/2013 SE Recruitment campaign has been successful and vacant band 5 posts have been recruited into. The risk is on hold untill the date for CRS implementation has been agreed.
T036	33. Corporate	Risk to the Trust's reputation if the Friends & Family Test inpatient scores remain nationally in the bottom quartile.	Identified during RMC meeting then subsequently assessed	Quality	Moderate 3	Likely 4	12	3	12	Treat	EMC/Patient Safety Committee	Director of Nursing & Patient Experience	07/10/2013	06/11/2013	CQC Outcome 1 Strategic Objective 1	(1) Weekly review of FFT comments for wards. (2) FFT to be an agenda item at NMAC and sisters' meeting. (3) Review learning from questions regarding what patients would like us to improve. (4) Implement inpatient Experience Action Plan. (5) Improve FFT reporting interface	Work is currently being undertaken to look at options for improving the FFT reporting interface and this will be implemented in December 2013. This will also make it easier for staff to review FFT comments on a weekly basis. FFT is an agenda item at NMAC and sisters' meetings. Several actions have been implemented for the Inpatient Experience Action Plan and progress will be monitored at the next Patient Experience Committee.

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T_IMT009	21. IM&T	Risk that the Trust will incur significant additional costs as a result of failure to complete the procurement of and transition to a replacement PAS/EPR system when the national contract comes to an end in Oct 2015	Risk Assessment	Financial	Catastrophic 5	Possible 3	15	5	10	Treat	IM&T Steering Committee (& London Cerner CE Forum and London Cerner CIO forum) AC	IT Director	08/01/2012	13/12/2013	Outcome 21 Principal Risk /BAF 4 Principal Obj. 1 Strategic Obj. 5	Close monitoring of the established procurement programme with partner trusts. Early engagement and negotiation with Dept of Health about arrangements for an orderly transition. Detailed resource planning within the Trust to ensure all parallel initiatives are appropriately funded.	Procurement programme 1 month ahead of schedule & sufficient suppliers involved to achieve Framework contract - aiming for end-May '13. No agreement yet with DH on orderly transition arrangements - being progressed. Trust procurement to follow Framework & scheduled for Summer '13, in parallel with St George's. Aiming for June '13 for OBC to Trust Board. Resource planning being done as part of 13/14 business planning. Initial exit planning versus current deployment programme has exposed no risks that cannot be managed. OBC being developed Re-procurement paper due to go to Trust Board in September 2013. FBC due to go to the Trust Board in Jan 2014.
T021	33. Corporate	Risk to the quality of patient care from incomplete or unavailable health records LINK: AC_REC001, MAE_Ed002, SP004, AC_REC002, AC_REC003, IG008,	Risk assessment	Quality	Major 4	Likely 4	16	6	9	Treat	Patient Safety Committee QAC	COO	01/06/2011	30/04/2014	CQC Outcome 21 Principal Risk 1 Strategic Obj. 1	Health Records Improvement action plan developed lead by Project Manager. Regular audit programme.	Action plan delivered. Currently receiving notes within the Health Records to further improve flow of notes to departments 07/13; - Improvements in performance noted at the Health Record Programme Board - work continues. 10/13; staffing has been increased permanently to address previous shortfall
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	Quality	Major 4	Likely 4	16	6	9	Treat	Health & Safety Committee AC	Director of Estates and Facilities	08/11/2011	31/03/2014	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Action plan in place to ensure recruitment to Fire Safety Manager, compartmentation survey, fire evacuation equipment purchase and replacement of Esher and Maternity Fire Alarm systems.	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.
T_IMT013	21. IM&T	CRS UPGRADE - USER - Staff do not consistently comply with using the system.	Risk Assessment	Quality	Major 4	Likely 4	16	4	9	Treat	IM&T Steering Committee (& London Cerner CE Forum and London Cerner CIO forum) AC	Chief Operating Officer	16/05/2013	25/11/2013	Outcome 21 Principal Risk /BAF 4 Priority Obj. 1	- Divisions to ensure clinical information is recorded on the system for all aspects that are in scope for Phase 1. - Plan to developed for implementing real-time ADT prior to the rollout of e_prescribing -TBA - Intensive support for staff at go-live	Plan being developed for implementing real-time ADT Ward assessment undertaken - further work required Further work required on ADT's at different times of the day 10/13; Consequence reduced due to not going live with Medicenes

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T007	33. Corporate	Failure to win tenders for secondary care input at outreach locations.	Business and service delivery plans	Strategic	Moderate 3	Likely 4	12	6	9	Treat	FIC	Director of Strategic Development	27/12/2011	24/03/2014	CQC outcome 26 Principal Risk 9 Strategic Obj. 4	Strengthen bid capability through establishment of Commercial Directorate. Introduce GP engagement programme. Proactively work with Merton commissioners and GPs to develop outreach services at Raynes Park Health Centre. Proactively work with Kingston commissioners to develop outreach services at Surbiton Hospital.	Commercial team and GP engagement programme in place. 07/10 - Outreach services at Raynes Park HC now open. Business case agreed for provision of KHFT outreach services at Surbiton Hospital. November 2013 Board horizon scanning session
T008	33. Corporate	Competition from other providers affects the Trust's income position and financial viability	Business and service delivery plans	Strategic	Moderate 3	Likely 4	12	6	9	Treat	AC	Director of Strategic Development	27/12/2011	21/03/2014	CQC outcome 26 Principal Risk 9 Strategic Obj. 5	Development of Commercial Strategy. Implementation of Commercial Strategy action plan. Strengthen bid capability through establishment of Commercial Directorate. Introduce GP engagement programme.	Comercial Directorate established and GP Engagement program in place Commercial Strategy update and action plan 2013/14 approved by Trust Board 10/13; November 2013 Board horizon scanning session
T005	33. Corporate	Failure to release sufficient costs as activity shifts to the community, resulting in an overall cost to the health economy	Risk Assessment	Strategic	Moderate 3	Likely 4	12	6	9	Treat	FIC	Director of Finance	01/04/2012	31/12/2013	CQC Outcome 26 Principal Risk 9 Strategic Obj 3 & 5	Productivity programme to include contingency. 5 year savings plan to cover full value of QIPP. Trust to actively monitor activity and referrals to discern is activity shifts are taking place	6/13; Review of 'market share' report shows no discernable shifts 10/13; Productivity plan contains contingency
T_MAE_AM007	12. Acute Medicine	Lack of provision of psychogeriatric inreach to review and advice on behaviourally challenged elderly (largely due to consequences of dementia and delirium). This results in patients not being managed on the appropriate clinical pathway	Recommendations from other external high level enquiries and reports	Quality	Moderate 3	Likely 4	12	6	9	Treat	Divisional Board QAC	Divisional Director Divisional Manager Clinical Lead		29/11/2013	CQC outcome 6 & 7 Principal Risk 1 & 5 Strategic Obj. 1, 2 & 3	1. Complete integrated CQUIN milstones. 2. Agree funding required to support the appointment of Mental Health Nurse. 3. Agree SLA with Mental Health Provider.	Many have 1:1 nursing, ad hoc review by psychogeriatricians Risk reviewed 23/08/12 - Risk to be reallocated to Dr Chooi Lee. Same contacted for an update but on leave until 4th Sept. 14/11/12 SP Meeting to be held to discuss with external stakeholders geriatric psychiatric input. 5/12/12 JE meeting held there was an acceptance that further input was required and an action plan is being developed by DR CL. 5/3/13 JE This is being considered as part of the dementia CQUIN 03/05/13 SE The requirments of the CQUIN are currently being negotiated and consideration is being given to the appointment of a Mental Health Nurse. 26/06/2013 SE Awaiting confirmation from CCG re the service to be commissioned from St Geoge's Mental Health Trust.

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WCH_MAT010	08. Maternity	Financial impact under new maternity tariff caused by recharging process. The pathway tariff is paid to one provider and will be the first provider where the patient first books. There are currently no robust systems for checking if patients have booked in another unit other than asking patients and we have evidence that patients do not always admit that they are double booked. This could result in a significant financial impact if unable to recharge other units.	Risk Assessment	Financial	Major 4	Possible 3	12	3	9	Treat		Divisional Manager	23/09/2013	23/12/2013		There is work underway nationally to provide a database for cross checking NHS numbers and track maternity patient	
T033	33. Corporate	Skills Development Risk that the staff (Managers and Clinicians) do not have the skills and time to support SLM during the transition Link to SLM007 and SLM006	GPG/EMC risk assessment Consultation document	Quality / Finance	Moderate 3	Likely 4	12	3	9	Treat	EMC	CEO	13/09/2013	31/10/2013		•Management and leadership development programme •Coaching programme •Internal training •Review of short term interim support for clinicians and managers new to post	Management and leadership development programme tender returns shortlisted. Wave 1 of coaching training commenced. Internal training in development.
T012	33. Corporate	Risk that partnerships do not deliver anticipated benefits	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	AC FIC Trust Board	Chief Executive	01/12/2011	30/06/2014	CQC outcome 6 & 26 Principal Risk 7 Strategic Obj. 3	Review effectiveness of robust project management of strategic Alliance Partnership with St George's. Continue review of all external partnership contracts as per Corporate Objectives 12/13 Continue to participate as a full partner in SWL Pathology Programme to oversee the delivery of the identified benefits	SAP continues to meet and review risk register for the joint work. All partnership contracts reviewed, including external due diligence of SWLEOC. Outcomes of these reviews were presented to FIC and Trust Board where appropriate. Actions were agreed where necessary. CEO is SRO of SWL Pathology Programme. Regular updates to Trust Board. Ventures & Partnership Risk Register is being created at which point this overarching risk will be replaced with specific risks
T016	33. Corporate	Risk that implementation of CIPs adversely affects the quality of patient care and the patient experience.	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	Productivity Board QAC	Productivity Director	01/12/2011	30/04/2014	CQC outcome 16 Principal Risk 1 Strategic Obj. 1 & 5	Quality impact assessment of all CIPs. Development and monitoring (including challenge sessions) of quality indicators for each scheme at PPB/QAC/Trust Board.	Quality impact assessment and challenge sessions for all CIPs underway. Quality indicators identified, and monitoring dashboard under development for presentation at June PPB.

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T_HR009	24. Human Resources	Risk that the Trust will be unable to deliver the cultural change necessary to support change and that staff do not feel able to influence decisions about delivery of services.	National Staff survey	Strategic	Moderate 3	Possible 3	9	6	9	Treat	AC	Deputy Director of Human Resources	10/04/2012	31/03/2014	CQC outcome 12 & 14 Principal Risk 1, 5 & 6 Priority Obj. 3 Strategic Obj. 1 & 2	Staff Survey action plan developed. Work of the regular Trust Partnership Forum. Workforce Strategy. Appraisal changes 2013/14.	OD programme and Workforce Strategy progressed. Workforce strategy re-freshed November 2012. Staff survey 2012 evidenced more engaged staff. Appraisal underway.
T025	33. Corporate	Poor compliance of mandatory training resulting in staff being potentially out of date with current practice LINK: T_AM004, GS001	Internal audits	Quality	Moderate 3	Possible 3	9	6	9	Treat	Executive Management Committee QAC	Director of Workforce & OD	06/03/2012	30/01/2014	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.	Overall uptake currently 61% (end October 2013) Manager accountability strengthened with SLM. On line training re-launched. PDR check of compliance. IG training available on-line. Reports available by service line.
T006	33. Corporate	Failure of QIPP Action plan to achieve the reduction in volumes expected by GPs and PCTs resulting in financial tensions in the local health economy This risk is defined to relate to 2013/14 primarily	Risk Assessment	Strategic	Moderate 3	Possible 3	9	6	9	Treat	FIC	Finance Director	04/04/2013	31/12/2013	CQC outcome 26 Principal Risk7 & 9 Strategic Obj. 3 & 4	The Trust and PCT have used the BSBV process to align plans for growth & QIPP for 2013/14 Liaising closely with PCT to understand how progressed / effective the PCT plans are. Co-ordinating all interactions on demand management with the Trust through the contracts team and disseminating from there.	RISK INCLUDES T010 WHICH IS NOW CLOSED (30/11/2012) SM CCGs have articulated a certain degree of specificity for QIPP schemes for 2013/14. 10/13; Trust is performing well against QIPP. Over performance noted in initial months, but this has been reduced.
T_WCH_PAE003	10. Paediatrics	Reported delays in triage and treatment for children waiting in paeds A&E impacting on patient safety and paediatric medical and nursing staff resources	risk assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	DRB	Consultant Paediatrician & Head of Nursing	17/05/2013	10/12/2013	CQC Outcome 4 & 13 Principal Risk 1 Strategic Obj. 1	Review escalation processes and regular meetings between Paeds & A&E to discuss resource and progress. Moving towards GP referrals direct to paeds to reduce workload on Paeds A&E nurses.	04/06/13 TN Escalated as agreed at the Divisional Board on 17/05/13 due to Delays to triage and treatment for children attending paediatric A&E impacting on patient experience and increased demand on paediatric medical and nursing resource. 3/7/13 TN A&E have put forward a business case for a triage room which will go to the capital committee on 18/7/13. 05/11/13 DP Business case is still being reviewed by Operations Manager for ED.

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T_MAE_AM013	12. Acute Medicine	Risk of patients developing Stage 3 pressure ulcers whilst in hospital ED005 and T_MAE005	Risk Assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	Monthly Divisional Board	Head of Nursing, Medicine	07/05/2013	29/11/2013	CQC outcome 7 Principal Risk 1 & 2 Priority Obj. 3 Strategic Obj. 1	1. Ensure that inspection of skin integrity begins on admission 2. Accurate documentation of skin integrity and ongoing care including use of pressure relieving equipment 3. 2 hrly rounding 4. Prompt referral to TVN 5. Skin to be inspected prior to discharge 6. Improved communication with partnered organisations regarding the care of pressure ulcers on discharge.	1. Assurance by all staff in form of signed document, verifying competence in Waterlow/MUST scoring 2. Revision of notes for EDOU to include documentation of waterlow/MUST scoring for appropriate patients groups 3. All trained staff to receive Tissue Viability and Wound management training from TVN specialist Risk Reviewed 23/08/12 - Risk rescored at 9 (3x3) in light of recent cluster of pressure ulcer SI's. To be escalated back up to the corporate risk register Add to action plan: 1.Work has begun on updating the nursing documentation in the ED to improve compliance 2.CRS update – skin integrity fields to be made mandatory so staff have to complete the assessment before moving to next screen – E Duffy leading on this project. 3.Trust policy has been updated. This is to be promoted in all clinical areas to ensure staff a aware of changes Reviewed at the DRB 28/06/12 No change in risk score 14/11/12 SP C P to introduce the new SBAR handover system on the medical wards which included information on pressure ulcers. CP to report on progress at Jan DRB Discussed 24/1/2013 at DRB contiue implementation of existing action plans and review in light of proposal to reduce size of wards and redifined establishments 22/03/2013 Continue to monitor. Pressure ulcer bundle in place. 03/05/2013 SE Compliance with Pressure Ulcer documentation has improved from 60% to 88% from Nov 12 to April 13. The Division has seen a reduction in Hospital acquired Pressure Ulcers by 59% in 2012/13 as compared to 2011/12. 05/07/2013 SE Matrons to check that the daily bedside handover is happening and the new admission checklist is completed.
T_MAE_AM016	12. Acute Medicine	Risk of not being able to provide adequate acute capacity because of delayed transfer of care.		Quality	Moderate 3	Possible 3	9	6	9	Treat	Divisional risk board	Therapy manager	24/01/2013	29/11/2013	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 5 days length of stay meetings. 4. To incorporate DTOC into CQUIN	5/3/13 JE Improve escalation process for delays to improve ward round and board reviews, by agreeing who leads & when it happens having a consistent format. Analyse the reasons for the increase in patients staying over 3 weeks and implement action plan. 03/05/13 SE Escalation process now in place. Over 5 days length of stay meeting in the process of redesign. 05/07/2013 SE Analysis of DTOC has been undertaken as part of CQUIN of frail elderly. One additional discharge coordinator has been appointed and to support the increase in HMAs. JG CCG Commissioning Manager has set up a cross-organisational group to review and reduce DTOC. This group is a sub-group of urgent care board.

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T_WCH_GYN003	07. Gynaecology	Limited capacity on Isabella ward for Gynae patients impacting significantly on patient experience. Patients being placed in inappropriate locations, delays in getting patients to theatre impacting on elective activity. Patients staying in recovery for protracted periods.	Risk Assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	Divisional risk board	Head of Peadiatric Nursing	16/11/2012	29/11/2013	CQC outcome 4 Principal Risk 1 & 2 Strategic Obj. 1	Utilising assisted conception unit recovery for EPRCs Daily review by Head of nursing or DM to discuss plan.	paper being produced for Emc to move isabella & Jasmine to Elliot ward. Proposed plan to move end of May 2013. 19th July MMC arranging a task & finish group to push this forward. May need to involve executive at meetings but will wait for first meeting and review against deadlines and slippage.
T_AC_PAT0019	17. Pathology	Lack of progress in SWL SAP plan is impacting on staffing in Pathology. Instability in the system is affecting morale resulting in staff leaving and diffculty in recruiting, impacting on the ability to deliver a reliable 24 hour service. Shortages could impact on our accreditation status.	Risk Assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	Divisional Risk Board	Pathology Manager Divisional Manager	17/05/2013	28/11/2013	CQC outcome 13 Principal Risk 1, 2 & 5 Priority Obj. 3 Strategic Obj. 1, 2, 3 & 4	1)Workforce plan being developed to predict potential staff loses and to ensure early recruitment interventions 2)Workforce plan and pay budget monitoring will predict budgetary impacts will ensure Pathology / Division is aware of fiscal pressures and develop mitigation plans where possible 3)Pathology KPI's developed to monitor impacts to QMS 4) SWL Pathology have devised actions to reduce restrictions on recruitment process.	17/05/2013 1)Using staff plan predictive tool work within sector HR plan to re-distribute staff resource or activity across sector to match demand to capacity 2)If SW London sector cannot support early transfer of resource / demand – Seek support from non-sector NHS providers or private providers as required 3)Transfer cold services at risk to SW London hub in advance of planned timescale – Requires assurance of HR process and development of infrastructure and sector capacity Success of strategy will vary dependent upon pathology discipline 20/09/13 SE Internal and external factors are reducing the effectiveness of the action plan. Retaining as many former employees as possible on bank roll to cover OOH service. To be reviewed towards end Nov 13 on account of TUPE consultation conclusion.
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	Quality	Major 4	Likely 4	16	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	17/01/2012	30/04/2014	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Policy for management of electrical installations to be drafted and competency of staff undertaking electrical work to be established. Further funding needs identifying to install UPS/IPS in High risk patient areas including Main theatres and Maternity.	New generator installed. Electrical Infrastructure work to be commenced in Esher Wing in 2013/14 as per Estates Maintenance Plan. 10/13; work currenlty being planned

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T_EST005	22. Estates	Management of legionella and water: potential in water systems for debris from corroded pipework and risk of legionella bacteria.	Risk Assessment	Quality	Major 4	Possible 3	12	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	07/02/2012	31/03/2014	CQC outcome 10 Principal Risk 2 & 3 Strategic Obj. 1	Investment is needed to replace old pipe work and up grade the water system to further prevent and reduce bacteria count. Further replacement pipework planned 2012/13 and 2013/14.	Some pipework replaced in 2011/12. Rigorous, robust monitoring of legionella undertaken weekly. Water testing carried out routinely for bacteria and management system in place for treating any findings. Pro-active flushing, tmv, removing dead legs and treating. Quaterly audits by external contractor, Water safety meetings monitoring actions from testing. Capital program for 2013/2014 for replacing pipework. 10/13 work to replace pipework has now commenced
T_SCC_TCS007	04. Theatres / ICU / SSD	Bed capacity constraints within ICU impacting on the ability to manage acutely unwell patients and resulting in increased non-clinical transfers	Risk Assessment	Quality	Major 4	Possible 3	12	4	8	Treat	Divisional board	Divisional Manager	31/03/2012	24/12/2013	CQC outcome 4 & 10 Principal Risk 1 Strategic Obj. 1	Flexibility with beds / annual leave throughout the year. To be monitored monthly. Restricted number of staff allowed off at any one time. Attend bed management meeting daily - advance planning for potential discharges in forthcoming days. Adherence to the Critical Care discharge policy Trust wide.	Regular recruitment Staff Leave strictly managed. Data being collated on a daily and weekly basis on numbers of discharges with a view to monitor their timeliness. 17/8/12 JE Capacity issues still of concern waiting times to refer patients out of the unit to be monitored against policy Timely and appropriate escalation of delayed discharges. 24/12/12 JE high risk due to VRE which is limiting out of hospital transfers. 30/01/13 JE implemented VRE action plan Having twice daily floor cleaning Converted an admin post in to a housekeeper post, Addressed staffing issues. 5/3/13 Je Capacity managed on a day to day basis with controls in place to control staffing issues. 8/7/13 TN Risk continue to be monitored regularly with no significant movement
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	29/11/2013	CQC outcome 26 Principal risk 9 Strategic Obj 3 & 5	Development of robust 5 year business plan. Inclusion in Better Services, Better Value. Maintain flexibility to respond to any emergent changes in demand as required.	Robust 5 year business plan developed. Involvement in Better Services, Better Value programme on going. Plans developed to respond to potential outcome of BSBV, which may be positive for the Trust
T031	33. Corporate	Failure to meet Monitor requirements resulting in breach of licence Link to T029	Risk Assessment	Strategic	Major 4	Unlikely 2	8	4	8	Treat	Trust Board, APSG, FIC	Chief Executive / Head of Corporate Affairs	04/06/2013	09/01/2014	Principal Risk 2 & 8 Strategic Obj. 5	•Board review against Licence in March 2013 •Board re-reviews planned •Process for submitting ¼ ly returns reviewed by APSG, FIC & Board •Weekly review performance against targets at EMC •Cancer action plan monitored at Divisional Board •HCIA action plan	•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

Risk Ref	Speciality	Description of Risk	Source of Risk	Type	Consequence	Likelihood	Initial Risk	Target Risk	Current Risk	Risk Response	Monitoring Body	Risk Owner Title	Start Date	Review Date	CQC Outcome / BAF	Action Plan	Progress Against Action Plan
T_MAE_AM021	12. Acute Medicine	Risk of not being able to provide staff to support to those patients requiring help to eat and drink at meal times and to optimise their nutritional intake.	Risk Assessment	Quality	Major 4	Unlikely 2	8	4	8	Treat		Divisional Manager	01/07/2013	31/12/2013		1. Protect mealtimes. 2. Ward rounds to be commenced on time to ensure completion prior to 12:30. 3. Number of patients needing support to be given to bleep holder daily. 4. Evening drinks round. 5. Recruit promptly into vacant posts.	30/10/2013 SE Recruitment campaign has been successful and actions have been implemented. The next step is to review the impact of implementation.
T035	33. Corporate	Interrelationship Risks that the service lines, corporate services and supporting IT do not move at the same pace. Risk that SL inter-relationships stay under-developed for too long. Risk that the pace of SL development is too slow Link to SLM002,SLM003, SLM004 and SLM005	GPG / EMC risk assessment Consultation document	Quality / Finance	Minor 2	Likely 4	8	2	8	Treat	EMC	Director of Finance Director of Strategic Development Head of Quality & Risk Assurance Head of Information Services	13/09/2013	31/10/2013		Re-alignment of roles within corporate teams Recruitment in BI team 'Lot 4' of OD programme • Management of accreditation pipeline. • Provide training for all Clinical Directors. • Ensure pace of change is as fast as practically possible. • Ensure effective governance of the implementation of SLM.	Corporate team roles clarified. BI team interviews underway. "Lot 4" of OD probramme tender returns shortlisted. Accreditation pipeline under development. Internal and external training for CDs under development. Pace of change already commenced with structural and governance changes in place. SLM implementation risk register developed.