Corporate Risk Register as at 25th March 2014

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
T037	33. Corporate	Implementation of the 'Better Care Fund' agenda results in a significant net financial deficit to the Trust and/or inability to meet quality targets e.g. waiting times	Risk Assessment triggered by change of policy	Quality / Finance	Major 4	Likely 4	16	12	16	Treat	EMC	Director of Strategic Development / Cheif Executive	29/11/2013	30/05/2014	CQC - Responsive Strategic Objective 5	Work collaboratively and proactively with partners to develop plans for integrated care Increase CIP target for 2015/16 and develop plans Develop commercial strategy to identify other potential income sources	02/14 - Discussions are ongoing with partners. - 2015/16 CIP plan has been developed. - The Commercial Strategy if being refreshed for March 2014. 03/14 - CRC reviewed the risk and agreed to reduce the consequence score to 4 from 5 reducing the overall risk score 16 from 20.
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. 12/13 - Schemes are currently being worked up with Service Lines for the 2014/15 programme. Each clinical division has been allocated an Executive lead to support the development of their programme with meetings to review ideas commencing early December. Finance teams will support their service lines with the development of the schemes. The PMO will co-ordinate and review the programme and ensure the quality and equality impact assessments are completed for each scheme.
T_MAE003	12. Elderly Care	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	Performance Review Meeting	Service Line Manager Associate Director	27/03/2013	29/05/2014	CQC outcome 4 & 7 Principal Risk 1 Strategic Obj. 1	1. Accurate risk assessments to be carried out within 6 hrs of admission 2. ensure implementation of Fall Policy 3. RCA investigations for all moderate harm falls including action plans 4. Review number and severity of falls each month and analyse trends 5. Ensure monitoring of falls and post falls bundles. 6. Analyse co-relation between falls incidents and increase in the admission of over 75 years of age and length of stay. 7. Ensure effective night lighting	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. 20/12/13 SE Monthly falls group monitoring falls rates and receives reports from wards with high incidents. Project Manager concluding review and present a report towards the end of Jan 14 20/03/14 TM 1. Falls bundle is being changed and the six monthly audit took place on 17th February 2014. 2. More falls alarms have been made available to the ward teams 3. Keats is planning to trial the use of alarms in the toilets. 4. Falls rates on the care of the elderly wards continue to be monitored closely at the service line meeting.
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	28/05/2014	Stategic Obj 2 CQC Outcome 14 Principal Risk 5 Priority Obj. 3	Management of SLM leadership development underway. Bottom up approach to developing CIPs for 2014/15. Budgets and plans for 2014/15 clarifying expectations and capacity required being developed at Service Line level. Training plan for CRS rollout developed.	OD programme approved by Trust Board. Programmes being monitored by EMC. CRS planning complete but implementation delayed. Pathology (SWLP) approved. Leadership development partner appointed and programme started. Business planning process for 2014/15 simplified. 02/14 - DG reviewed and changes made.
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	20/06/2014	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 12/13 - No change to risk score. Broader OOH issues are being addressed by the Deputy CEO.
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	Deputy Chief Executive	04/12/2012	28/03/2014	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.

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T040	33. Corporate	Risks identified from the Frankham Consultancy Business Critical Review and the development of the Estates Strategy regarding the failure of engineering systems and buildings which are beyond their useful life may be realised.	Assessment and amalgamation of local risks	Finance / Stategy	Moderate 3	Likely 4	12	6	12	Treat	Trust Board Health & Safety Committee	Director of Estates	11/02/2014	04/04/2014	Outcome 10. Principal Risks 2 & 3. Strategic Objective 1	Action plan to be created for the new risk.	
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	30/06/2014	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 blinds and additional heaters are being sourced. 21/3/14 HG reviewed - For this winter, new blinds and additional heaters were sourced and the weather was mild all of which mitigated the risk for winter 2013/14.
T_IG005	25. Information Governance	Risk of ICO fines through data breaches e.g handover sheets not being properly disposed of, emails being sent to incorrect destinations		Financial	Major 4	Possible 3	12	4	12	Treat	Information Governance Committee	Finance Director	06/03/2012	31/03/2014	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. 12/13 - 2 presentations on topic at Team Brief; training modified to emphasise PID risks; will discuss risk score at the next IGC
T032	33. Corporate	Transition to SLM: Establishing Devolved Structure Transition to SLM could lead to reduction in control (eg. performance / finance) and other priorities getting pushed back. This is exacerbated by the fast pace Link to SLM009,SLM011, SLM010 and SLM012	GPG / EMC risk assessment Consultation document	Quality / Finance	Major 4	Possible 3	12	4	12	Treat	EMC	CEO	13/09/2013	30/04/2014		Recruitment to posts happening quickly. Training programme being devised and rolled out. Deployment of new governance structure. COO / DoF still reviewing performance Ensure knowledge and expertese not lost within Trust	11/13 Recruitment complete although some new post holders are yeat to start. New governance structure in place and first meetings are being held. Trainees identified and dates set for budget training. 12/13 Associate Director for Specialist Services now started. 02/14 Reviewed by NH - no update.
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	28/03/2014	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	Dec 13 - An improved FFT reporting interface will be implemented in January 2014. FFT has been discussed at NMAC and sisters' meetings. Ward sisters are encouraged to look at their feedback on a weekly basis. An initial analysis of data regarding what patients would like us to improve has shown that perceptions about staff numbers, hospital food and waiting times are 3 main areas where people feel we should be focusing our work. 03/14 - The quarterly qualitative analysis of FFT comments now in place from Feb 14 pending greater granulation of information for wards or areas of focus. Programmes of work to improve food and assistance with meals in place. Safe staffing programme in place to address staffing perceptions.
T_EST002	22. Estates	Risk of non compliance with statutory requirements for fire alarm and detection systems, compartmentation, escape lighting, evacuation procedures and equipment and training. Link: SCC_TO006, TCS020	Risk Assessment	Health & Safety	Major 4	Likely 4	16	6	9	Treat	Health & Safety Committee AC	Director of Estates and Facilities	08/11/2011	30/06/2014	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. 21/03/14 - HG reviewed, no new update.
T021	33. Corporate	Risk to the quality of patient care from incomplete or unavailable health records LINK: AC_REC001, MAE_Ed002, SP004, AC_REC002, AC_REC003, IG008,	Risk assessment	Quality	Major 4	Likely 4	16	6	9	Treat	Patient Safety Committee QAC	Deputy Chief Executive	01/06/2011	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_TO015	05. Trauma and Orthopaedics	Delay in scheduling patients for surgery or outpatient appointments, resulting in potential delay in failure to meet the 18 week referral to treatment standards.	Risk Assessment	Quality	Moderate 3	Likely 4	12	9	9	Treat	T&O risk meeting	Operational Manager	17/01/2014	02/06/2014		Run three teams to support clinicians and a fourth team as a communication hub to respond to all patient calls. Provide additional 18 week referral to treatment training for administrative and clerical staff. Review format of outpatient and DSU / Inpatient letter to ensure that the correct departmental telephone number	
T_EST023	22. Estates	Incorrect segregation of waste remains an issue which creates a high financial risk for the Trust and also a risk of prosecution. Training in key areas underway.	Environmental	Financial	Moderate 3	Likely 4	12	6	9	Treat	Health & Safety Committee	Director of Estates & Facilities	01/01/2013	04/04/2014		Waste management policy and training of staff on waste segregagtion included in Trust Sustainable Waste Action Plan and planned projects and pressing issues on waste are discussed and ways to resolve them are addressed at monthly Waste Committee meetings and reported to the Health & Safety Committee Meeting	Trust Sustainable Waste Action Plan in place. Trust staff are trained on corrrect waste segregagion during mandatory training delivered by Trust Health & Safety Department. There are been reduced non-confirmance for waste especially with the introduction of the Orange clinical and Tiger waste streams which has reduced waste disposal costs and segregagtion issues. Main issue is to introduce mixed recycling to effectively place the Trust in a position where disposal costs of domestic waste is reduced to the bearest minimum.
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	31/03/2014	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 12/13 - no change

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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	28/03/2014	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	28/03/2014	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
T_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		Service Line Manager	23/09/2013	08/04/2014		There is work underway nationally to provide a database for cross checking NHS numbers and track maternity patient	This is dependent on CCG / CSU triangulation exercise. This is now scheduled for Q4 2013/14 14.01.2014 The amount of cross-charging has not materilaised. However, there is a possibility this may change as Trusts get closer to the end of the financial year. REVIEW: April 2014
T033	33. Corporate	Transition to SLM: Skills Development Risk that the staff (Managers and Clinicians) do not have the skills and time to support SLM during the transition Link to SLM007 and SLM006	GPG/EMC risk assessment Consultation document	Quality / Finance	Moderate 3	Likely 4	12	3	9	Treat	EMC	CEO	13/09/2013	30/04/2014		•Management and leadership development programme •Coaching programme •Internal training •Review of short term interim support for clinicians and managers new to post	Wave 1 of coaching training commenced. Internal training in development. 11/13 Management and leadership development programme providers selected and programme under development. 02/14 Reviewed by NH - Leadership programme commenced.
T_AC_PAT0019	17. Pathology	Lack of progress in SWL SAP plan is impacting on staffing in Pathology. Instability in the system is affecting morale resulting in staff leaving and diffculty in recruiting, impacting on the ability to deliver a reliable 24 hour service. Shortages could impact on our accreditation status.	Risk Assessment	Quality	Moderate 3	Possible 3	9	6	9	Treat	Performance Review Meeting	Pathology Manager Service Line Manager	17/05/2013	14/06/2014	CQC outcome 13 Principal Risk 1, 2 & 5 Priority Obj. 3 Strategic Obj. 1, 2, 3 & 4	1)Workforce plan being developed to predict potential staff loses and to ensure early recruitment interventions 2)Workforce plan and pay budget monitoring will predict budgetary impacts will ensure Pathology / Division is aware of fiscal pressures and develop mitigation plans where possible 3)Pathology KPI's developed to monitor impacts to QMS 4) SWL Pathology have devised actions to reduce restrictions on recruitment process.	17/05/2013 1)Using staff plan predictive tool work within sector HR plan to re-distribute staff resource or activity across sector to match demand to capacity 2)If SW London sector cannot support early transfer of resource / demand – Seek support from non-sector NHS providers or private providers as required 3)Transfer cold services at risk to SW London hub in advance of planned timescale – Requires assurance of HR process and development of infrastructure and sector capacity Success of strategy will vary dependent upon pathology discipline 20/09/13 SE Internal and external factors are reducing the effectiveness of the action plan. Retaining as many former employees as possible on bank roll to cover OOH service. To be reviewed towards end Nov 13 on account of TUPE consultation conclusion. 13/12/2013- the risk is that it still presents a risk to service sustainability – but it is being managed at KHFT by a strong recruitment programme and agency staff. Presently working on a plan to maintain accreditation status but there will be non compliances identified
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.
T_MAE_AM016	12. Elderly Care	Risk of not being able to provide adequate acute capacity because of delayed transfer of care.		Quality	Moderate 3	Possible 3	9	6	9	Treat	Performance Review Meeting	Therapy manager	24/01/2013	31/05/2014	CQC outcome 4 & 7 Principal Risk 1 & 2 Strategic Obj. 1	1. To ensure that mdts are held on each ward to expedite decisions and discharges 2. To pilot MDT ward rounds. 3. To redesign 10 days length of stay meetings. 4. To incorporate DTOC into CQUIN	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. 13/12/2013 SE Weekly length of stay meetings have now been revised with leadership from Dr Chooi Lee. Two additional discharge coordinators in post supporting a reduction in HNA's. Navigator role in post and work taking place with community provider to define post holder's responsibilities. 17/12/13- CB- The Length of stay changed from 5 to 10 days 20/12/13 SE Winter plan developed and shared with partner agencies. Project group developed and patient flow manager appointment made.

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T_WCH_PAE 003	10. Paeds & NNU	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	25/04/2014	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. 13/12/13- its is now evident that this is a staffing issue and a meeting with the Director of Nursing is scheduled week commencing the 16th to discuss this satffing issue. This issue is compounded at present with paediatric capacity and acuity during winter months. 30/1/2014 - Additional third nurse employed in A&E for winter months during peak times. Addtional paediatric SHO employed during day shifts at weekends for A&E, additional registrar for twilight shifts during weekdays. Improved situation in A&E but paediatric attendances are high which results in late referrals to the paediatric team. There are greater numbers of sick children requiring high intensity treatment, bed availability in PICU is resulting in sicker children being transferred and cared for on the paediatric ward. MC Paediatric and A&E consultants have met to agree a pathway for patients to maintain safety and also prevent breaches when possible. The paediatric and A&E senior nurses met and agreed processes to maintain flow of patients and maintain safety. MC 19.2.2014
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	31/03/2014	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. 12/13 - Initiate and complete Q3 SLA reconciliation	RISK INCLUDES T010 WHICH IS NOW CLOSED (30/11/2012) SM CCGs have articulated a certain degree of specificity for QIPP schemes for 2013/14. 10/13; Trust is performing well against QIPP. Over performance noted in initial months, but this has been reduced. 12/13 - Q1 reconciliation with CCG successfully completed
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. 12/13 The newly formed Quality Improvement Working Group (QIWG) will provide assurance that the Cost Improvement Programme will not adversely affect the quality of care provided. Quality and Equality Impact Assessments (QEIAs) will initially be reviewed within service lines, then by the PMO prior to being signed off by the QIWG. Any schemes for which there are concerns about the quality impact following this process will be returned to the service line to mitigate any risks to quality.
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	28/05/2014	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 69% (Feb 2014). Manager accountability strengthened with SLM. On line training re-launched. PDR check of compliance. IG training available on-line. Reports available by service line. 02/14 - DG reviewed and made changes.
T_EST004	22. Estates	Risk of enforcement action under the electricity at work regulations because of non compliant electrical infrastructure including lack of suitable UPS and IPS in high risk patient areas. Link:TCS005, TCS001	Risk Assessment	Health & Safety	Major 4	Likely 4	16	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	17/01/2012	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 currently 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	Health & Safety	Major 4	Possible 3	12	4	8	Treat	Health & Safety Committee AC	Director of Estates and Facilities	07/02/2012	30/06/2014	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. Quarterly audits by external contractor, Water safety meetings monitoring actions from testing. 21/03/14 HG reviewed - Contractor has commenced work on main system and pipework within Esher Wing contract will continue in 2014/15. Proposals for Outpatients building being developed. Flushing regime data records 80% compliance.
T_EST026	22. Estates	Increased Energy Prices - Volatile Energy Prices. At present estates energy budget is 2.5million. The price increase has the potential to have a large financial impact.	Energy Supply & Demand	Financial	Major 4	Possible 3	12	4	8	Treat	Estates	Director of Estates & facilities	01/01/2013	30/04/2014		Follow Trust Carbon Management Plan	Gas prices have increased by over 50% in the past 3 years and are likely to keep on rising. Energy consumption across the Trust would continue to increase owing to more staff and more services been rendered. Investment in Energy efficient pojects set in the Trust Carbon Management Plan would ensure reduction in energy consumption and costs. A few of energy efficient projects have been carried out and business cases for some of the projects are been prepared to ensure rduction in energy consumptiom and set emissions targets are met. Trust has recently lauched a sustainability steering committe whose aims are to ensute energy comsumption are mitigated Trust wide through energy awareness behaviourail change programmes and implementation of energy efficinecy projects. External funding for these projects is also been sought through organisations such as Salix Energy Efficiency Scheme Loan
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	8	Treat	IM&T Steering Committee (& London Cerner CE Forum and London Cerner CIO forum) AC	Deputy Chief Executive	16/05/2013	03/04/2014	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. 18/12 - meetings held with Nursing staff to review impact of Meds rollout. 8/1 Lessons documented. Regular meetings held with nursing and medical staff on pilot ward and appropriate actions agreed. Estimate 75% complete. Working with ED to 'practice' following the new processes in with real patients to identify any issues and promote familiarity - estimate 25% complete. 20/1 reviewed, effectiveness of plan improved, score now sits at 8 17/2/12 - reviewed, original change actions completed, process review in Isabella completed. Process review in ED 95% complete. Process review commenced for Keats 19/3/14 - Isabella is 95% complete and due to go-live 7th April. Keats is 80% complete and work is ongoing to ensure they are ready by their go-live. All wards require an assessment approximately 3 months before their go-live to identify their processes and ensure there are no gaps. This will mean that this risk remains until deployment is complete in 2015.
T_SCC_TCS 007	09. ICU	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	Performance Review Meeting	Service Line Manager	31/03/2012	24/10/2014	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 15/11/13- MG, BB and DP- decision made to defer this review until Oct 2014 unless financial implications.
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	30/04/2014	CQC outcome 26 Principal risk 9 Strategic Obj 3 & 5	- Refresh 5 year business plan. - Participate in successful BSBV. - Maintain flexibility to respond to any emergent changes in demand as required.	- Work has commenced to support development plan by June 2014. - Awaiting details regarding the BSBV.

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
T028	33. Corporate	The failure to control the occurrence of C.diff resulting in poor outcomes and experience for our patients	Infection control - incidents	Quality	Major 4	Possible 3	12	4	8	Treat	EMC	Director of Nursing & Patient experience	06/12/2012	30/03/2014	Outcome 8 Principal Risk /BAF 1, 2, 8 Strategic Obj. 1	Implementation of 2012 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	Action points within the peer review action plan have been completed or are in progress. Internal Audit of compliance with antimicrobial policy has taken place. Complete additional actions in response to PIR's to ensure embedding of antibiotic practice and timely collection of stool specifmens required. 20/12/13 - External review of CDiff actions taken place on 5th Dec 2013 - report awaited, in order to address any further actions. Actimel roll out taking place and due for completion in Jan 2014. Complete online training for nursing staff. 03/14 - Report from external review received. The number of CDiff cases has reduced, Dec 13 - Feb 14 in comparison to prior month. Action plan to address CDiff peer review is taking place.
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	21/04/2014	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 12/13 - A Quality Governance Review has taken place and the update is going to the January Board. 03/14 - DL updated - In the Quarter 3 call with Monitor they confirmed they had given a green for governance and were satisfied around C.Diff.
T_RAD006	19. Radiology	Risk of inability to provide the required ultrasound service to patients due to difficulty in recruiting sonographers and a cost pressure when using agency staff.		Quality	Minor 2	Likely 4	8	2	8	Treat	Divisional and speciality risk board	Radiology Service Manager	01/06/2012	31/03/2014		Staff are working extra hours in order to provide a service. Radiology ultra sound are currently back filling Plan on going recruitment of obstetric sonography staff. Planning for an increase in obstetric sonography workload. Agency sonographers are brought in to provide required capacity. 18/11/2013- Extra clinics with Locum sonographers put in place. Time recource is being used for Patient Tracking list which is reviewed weekly.	11/06/12 - Jim Weir, Divisional manager and maternity divisional manager have had an initial meeting about Maternity Sonographers. To be reviewed 1/9/12 1/10/12 JE Produced a consultation paper which has just been agreed by the HR dept. The plan is to split out the sonography service between WCS and radiology. It is anticipated that this will take effect from 1/1/13. We have just appointed 1.5 maternity sonography staff and we are in the process of recruiting 3 WTEs in radiology. 4/12/12 JE Business case presented to APG awaiting guidance. 4/02/13 JE Business case passed awaiting HR input. 23/04/13 JE Medium term solution - rebanded the 2 vacancies to include an element of advanced practice to make the post more attractive. Long term - Train within the radiology department to commence in september 2013 with staff being qualified by September 14. 19/09/2013 SE Two trainee sonographers have been appointed in Sep 2013. Once the staff qualify, the need for agency cover would be greatly reduced. 18/11/2013- Radiology Clinical Governance meeting- Current capacity does not match the demand as there has been a 100% increase in demand. 1.5 rooms short of space to accomodate increased demand.2 Complaints were received regarding this issue in the last 2 months. There is evidence that we are loosing patients to neighbouring hospitals because of our waiting times. All these factors will prevent us from going to SLM. Decision to raise risk score to 8. 13/02/14 - Action plan progressing as forecast. Breach numbers reducing. Demand management in place for MSK requests. Meetings held with Kingston & Richmond CCGs. Capacity forecast and planned against for 2014/15 contracting round. New Radiology sonographer starts end Feb 2014 to enable work at Surbiton HC. Maternity Ultrasound staffing improved (no agency planned so far from 01/04/14). 2 Trainees qualify 2014. Breach position much improved with diagnostic waiting list compliance forecast from 1st April 2014 (96% w/e 16/03/14). JW 20/03/14

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
T035	33. Corporate	Transition to SLM: Interrelationship Risks that the service lines, corporate services and supporting IT do not move at the same pace. Risk that SL inter-relationships stay under-developed for too long. Risk that the pace of SL development is too slow Link to SLM002,SLM003, SLM004 and SLM005	GPG / EMC risk assessment Consultation document	Quality / Finance	Minor 2	Likely 4	8	2	8	Treat	EMC	Director of Finance Director of Strategic Development Head of Quality & Risk Assurance Head of Information Services	13/09/2013	30/04/2014		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. 11/13 Finance, BIU and Ulysses systems mapped to new structure. 02/14 Reviewed by NH - no update.