

Board of Directors: 8.3.18

Agenda Item: Bo.3.18.7

Report from the Integrated Governance & Risk Committee (IGRC) Held on 12 February 2018

Presented by:	Professor Clive Kay, Chief Executive	Author:	Donna Thompson, Director of Governance & Corporate Affairs
Previously considered by:	Integrated Governance & Risk Committee 12 February 2017		

Key points/ Executive Summary	Purpose:
1. Corporate Risk Register – New Risks added Two new risks have been added since the previous report to the Board of Directors. The details can be found on page 1 of the attached Corporate Risk Register Movement Log.	To note and gain assurance
2. Corporate Risk Register – Risks that have changed in Score Four risks have changed in score since the previous report to the Board of Directors. The details can be found on page 2 of the attached Corporate Risk Register Movement Log.	To note and gain assurance
3. Corporate Risk Register – Risks Removed or Closed Four risks have changed been removed or closed since the previous report to the Board of Directors. The details can be found on page 3 of the attached Corporate Risk Register Movement Log.	To note and gain assurance
4. Divisional risks escalated to the Corporate Risk Register One risk from Women & Children's Division has been recommended for escalation to the Corporate Risk Register:- <ul style="list-style-type: none"> - ID 3200 - Insufficient security in maternity and risk of baby abduction – this was agreed to be escalated to the CRR One risk from Informatics Division has been recommended for escalation to the Corporate Risk Register:- <ul style="list-style-type: none"> - ID 3179 - EPR Error Log not being reviewed – this was agreed not to be escalated to the CRR as there is a mitigation plan in place. 	To note and gain assurance
5. Corporate Risk Register – Risks Scoring 12 and above The Corporate Risk Register (items scoring 12 or above) that was discussed at the IGRC on 12 February is attached.	To note and gain assurance

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Financial implications:
No

Regulatory relevance: CQC Standards
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Monitor:	Risk Assessment Framework
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Equality Impact / Implications:	<p>Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, what is the mitigation against this? Any impact on Equality & Diversity addressed through mitigation plans.</p>

Other:	
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Strategic Objective: <i>Reference to Strategic Objective(s) this paper relates to</i>	To provide outstanding care for patients

Corporate Risk Register Movement Log

Report date	08/02/2018
Prepared by	Sheridan Osbourne
Prepared for	IGCR 12.2.18

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

NEW RISKS TO CRR										
ID	Date of entry	Division	Description	Risk lead	Rating (initial)	Summary of mitigation	Target date for mitigation completion	Action plan lead	Current Rating	Rating (Residual)
3211	07/02/2018	Chief Operating Officer	There is a risk to patient safety from not delivering the national standards for cancer patients. Discussed at IGRC 15.1.18 agreed to be added to CRR.	Shannon, Sandra	15	February 2018: High level Cancer recovery Plan agreed with NHSI. Established patient level tracking and escalation plans.	30/04/2018	Jones, Laura	15	6
3204	15/01/2018	Chief Nurse	There is a risk that due to vacancies, sickness and additional capacity we will not be able to safely staff the nursing wards resulting in significant lapses in care and patient harm. New risk agreed to be added to CRR at 15.1.18 IGRC	Dawber, Karen	20	The following are in place: Daily safety huddles Daily RAG rating of staffing Optimal and minimum safety levels set Clinical site team presence 24/7 On call arrangements Clear escalation at divisional, local and corporate levels Exec level discussions prior to additional capacity being utilised Winter room in operation Clear escalation policies Utilisation of staff bank and agency Monitoring of Datix / incidents QuOC and corporate safety huddles 1 to 1's and regular reviews with heads of nursing Strategic staffing reviews Introduction of new roles including nursing associates and band 3 HCA's CHPPD and monthly reviews Heat map - wards vs harms reviewed monthly Weekly review of e roster and safecare	31/03/2018	Scales, Ms Sally	5	5

CORPORATE RISKS THAT HAVE CHANGED IN SCORE										
ID	Date of entry	Division	Description	Risk lead	Rating (Initial)	Summary of mitigation	Target date for mitigation completion	Action plan lead	Current Rating	Previous Rating
2547	14/04/2015	Chief Operating Officer	Failure to implement robust systems and processes to manage the Trust's Non-RTT cohort leading to the possibility of patient harm and reputational risk	Shannon, Sandra	15	7.2.18. non RTT waiting lists are being reviewed by divisions. Jan 2018: Full governance mechanisms including SOPs and reporting now in place post-EPR. Recommendation to next IG&R committee to close corporate risk. Aug 2017: SOPs are still actively followed and governance arrangements are in place. Turnover of administrative staff in the corporate access team has led to a worsened position with regard to the number of weekly validations. This will improve with recruitment. Clinical review is slow in some specialties. Divisions are actively managing this position. Post-EPR there will be the ability to trace the source of errors with correctly coding a patients status thus reducing the error rate. May 2017 brief report requested which describes the governance arrangements that are now in place to provide assurance of the systems and processes to manage our non RTT cohort. March 2017: governance arrangements in place and need embedding.	02/04/2018	Saunderson, Terri	3	12
2995	28/10/2016	Chief Nurse	There is a risk that we will not be able to staff the wards to the optimal levels due to vacancies, short term sickness absence and maternity leave resulting in inability to maintain high quality and timely care across the wards leading to increased patient complaints, minor safety issues and delays in the patient journey.	Dawber, Karen	20	January 18 - updated and likelihood of risk increased to 5 due to on going vacancies, increases in sickness over winter period and additional capacity and ward reconfigurations. Facebook recruitment and retention campaign has restarted with first open day held early January 18. We have planned programmes of activity throughout the year. The consequence of the risk has been reviewed and reduced to 2 - this is due to clarification that the risk refers to optimal staffing levels and not safe. A separate risk has been added under safe staffing levels with a consequence of 5 December 17 - Facebook business case approved, strategic staffing review to board in January 2018 October 17 new starters in place, ward staffing reviewed, roll out of safe care continues August 17 - in light of discussions at committee and that we are not due any new starters (in large numbers) until September likelihood has been increased to 5. June 2017 - Vacancy rate has now reached 15%. HCA recruitment positive. 92 RN's due to commence in September 2017. Continue to use bank and agency May 2017: Recruitment drive in place. NQN recruited to commence in September. SAFECARE in process of roll out. Daily staffing RAG continues to be completed. We continue to safely staff wards but may not always achieve planned staffing levels	30/06/2018	Scales, Ms Sally	10	16
3150	06/10/2017	Chief Operating Officer	Financial penalties and reputational impact in the failure to deliver 90% performance against Emergency Care Standard	Shannon, Sandra	16	Full governance structure surrounding the improvement plan with escalation to the Chief Executive. 6/2/18. The DCD is currently providing focused support to urgent care. The Acting CoO has reviewed the improvement plan to provide direction and drive in taking forward improvements. additional management support provided to the department. A business case has been approved for a new consultant post - Director of urgent care to provide senior leadership across the whole urgent care pathway	01/05/2018	Wilson, Dr Brad	15	9
3193	09/01/2018	Informatics	On 7th Dec 2017 an error was identified in third party provided service that meant some clinical correspondence had not been sent that included letters and discharge summaries that may impact on timely patient treatment and care.	Fedell, Cindy	12	7 FEB 2018: Correspondence identified for sending now processed. Additional monitoring and alerting in place. Closure of Serious Incident agreed with CCGs. Technical root cause analysis agreed and report being finalised. Jan 2018: About 10,000 documents in defined cohorts agreed with the CCG were sent directly to the relevant practices on the 12th December 2017 for usual review and general practice. A four stage process of review has been implemented for the remaining documents: o Stage 1: Administrative review: all documents are reviewed to identify any actions that were required to be undertaken by general practice. o Stage 2: Clinical risk review of all documents where potential actions were identified or where there was any uncertainty. o Stage 3: Associate Medical Director clinical review and management of any actions identified including liaison with the relevant Practice and identification of any potential or actual harm. o Stage 4: Medical Director/Deputy Medical Director review of any cases where harm or potential harm has been identified. Currently 2,462 documents to be reviewed as appropriate and sent out. All documents have been transferred to General Practice during a pre-defined time slot with a pre-agreed (with CCG and Medical Director) stamp to indicate that they were involved in the incident and had been subject to the administrative review process. To date there has been no evidence of any harm caused to patients. This is under continual review. Work is expected to conclude end of Jan 2018. All work is due to be completed by the end of January. Assurance has been implemented and monitoring/correlation of the number of letters leaving EPR and being received by Third Party Contractor is in place. Process with Practice Managers also being worked through to monitor/correlate number of letters leaving EPR and being received by Practice.	31/01/2018	Pagan, Kay	8	12

CORPORATE RISKS THAT HAVE BEEN REMOVED / CLOSED										
ID	Date of entry	Division	Description	Risk lead	Rating (Initial)	Summary of mitigation	Target date for mitigation completion	Action plan lead	Current Rating	Residual Rating
2892	19/06/2016	Informatics	EPR - Reduced productivity and activity from staff whilst training and implementation of the EPR system is completed could result in an unintended reduction in income impacting on the organisation's financial position.	Fedell, Cindy	20	<p>09 JAN 2018: Productivity is now at agreed volumes. There are a handful of clinics that have not and will not return to pre-Go-Live volume. This is being mitigated and managed with ongoing work on out-patient clinic optimisation, streamlining/training, and capacity & demand work.</p> <p>15 NOV 2017: EPR Steady State declared with some known clinics not back to full productivity. Plans being put in place to add back in volume from go-live reduction.</p> <p>11 OCT 2017 - EPR went live 24 Sep 2017 with planned reduction in clinics. Volumetrics now being monitored and interventions being taken.</p> <p>18 SEP 2017 - A reduction in out-patient clinics has been planned and costed. Expected volumetrics, along with several other data quality indicators, are planned to be reported daily to be corrected and escalated to Silver Command and Executive Directors. However data quality issues from other Trusts' go-lives indicate that data quality issues from data entry will occur and take time to correct and reduce, thus delaying accurate contract reporting.</p> <p>JUN 2017: Review of clinic schedule and assessment of capacity combined with support plans for Go-Live in progress.</p> <p>MAY2017: Benefit profiles and plans being updated for resubmission of FBC in July 2017.</p> <p>ich all have finance representation. All Divisions have action plans which are being monitored through to Operational Readiness Board.</p>	31/01/2018	Saunderson, Terri	20	10
3040	27/01/2017	Informatics	EPR - Costs have been revised due alterations to go-live dates. Date announced for CHFT as 29/4/17 with BTHFT expected to go-live 3 months later in August 2017. Delay beyond the new go-live dates has the potential to increase costs further, resulting in problems with cost containment.	Fedell, Cindy	12	<p>08 JAN 2018: Cost reconciliation will be completed in January 2018.</p> <p>15 NOV 2017: Finance conducting reconciliation of all final costs.</p> <p>11 OCT 2017: EPR went live 24 Sep 2017. Cost reconciliation being done as Early Life Support continues through Oct 2017.</p> <p>18 SEP 2017: Command and control continues with respect to cost controls. A review has been completed and a reconciliation provided. There is limited contingency left, so the risk will remain through go-live.</p> <p>JUL 2017: Business case updated and submitted.</p> <p>JUN 2017: Financial forecast updated and included in updated EPR Full Business Case to be presented to the Board in Jul 2017.</p> <p>MAR 2017: Regular review of finances in place with EPR Director and Finance. Review of resource needs through go-live drafted and being assessed/resolved in Mar 2017.</p>	31/01/2018	Smith, Chris	12	8
3066	13/03/2017	Human Resources	Risk of supply due to changes impacting on fill rates and risk of increased cost due to charge rates increasing for agency locums. There is also a risk to the Trust via HMRC if the Trust does not assess workers correctly.	Campbell, Pat	12	<p>Nov/December - actions ongoing. Significant assurance following audit on processes the Trust has in place re assessment of workers. October - actions ongoing.</p> <p>August/September - actions continuing. July - continuing to try and source locums from alternative on framework suppliers, reviewing different workforce options in particularly hard pressed specialties i.e. use of ACPs Other, as per control measures. Will continue to work to increase the number of agencies we use, to grow our internal banks and to encourage substantive recruitment where possible</p>	26/01/2018	Fletcher, Lisa	9	6
2453	24/07/2014	Strategy and Integration	Failure to adequately communicate and engage with all staff groups	Holden, John	9	<p>July 2017: Recruitment to all vacancies has taken place, new structure in place, but some (planned) sickness absence has meant team not yet at full strength..</p> <p>Internal (and external) Comms audits during July to better understand user preferences and inform development of refreshed BTHFT comms strategy for Board discussion in September. Working collaboratively with HR (Head of Organisational Development / Staff Engagement) to develop a sustainable internal and stakeholder engagement plan.</p> <p>Series of engagement events now adopting a common brand ("Lets Talk")to raise profile of staff engagement and make it more systematic. Particular emphasis on 1) leadership visibility 2) listening/effective conversations and 3) values (staff-led focus groups throughout summer)</p>	01/10/2017	Joy, Jason	6	6

Corporate Risk Register - Risks rated at 12 or greater

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

Report date **08/02/2018**

ID	Date of entry	Division	Description	Risk lead	Initial Rating	Summary of mitigation	Target date for mitigation completion	Action plan lead	Current Rating	Residual Rating
2150	20/11/2014	Finance	Ongoing Risk - Annually: Failure to maintain financial stability and sustainability in the current economic climate with the organisation facing continued cost inflation, tariff deflation, regulatory change, increased demand on services and a predicted curtailment of CCG growth funding.	Horner, Matthew	12	Dec 2017: October position reporting off plan I&E variance (both against the original plan and the improvement plan trajectory). Variance against improvement plan associated with income and activity capture, counting and coding - EPR Data quality group identifying and resolving issues with planned resolution date of 9.12.17 (to ensure data recorded for October freeze position). F&P committee discussed November delivery risk, with slippage impacting on subsequent months. Forecast remains on plan, with delivery of improvement plan throughout remainder of year to ensure full value of STF is secured. Delivery of the plan will be managed and monitored through the strengthened financial governance arrangements. Nov 2017:Limited Assurance Audit Report for CIP framework. Plan in place to deliver the actions by Dec 2017 AUG 2017: The Foundation Trust remains on plan at the end of Month 4 but is utilising non recurrent measures to deliver the position. An improvement plan is under development with the aim to sustainably and recurrently deliver the financial control total. APR 2017: The Foundation Trust has submitted a Financial Plan to NHSI that commits to delivering a surplus control total of £2m for the financial year 2017/18, inclusive of £9.8m STF funding. The CIP requirement equates to £20.2m. Delivery of the CIP and income & expenditure plan will be performance managed through the Trust Improvement Committee, Divisional Performance Review Meetings and Divisional Budget Meetings.	31/03/2018	Horner, Matthew	20	12

2893	19/06/2016	Informatics	EPR - Inability to achieve the expected benefits realisation affecting the organisation's financial position.	Fedell, Cindy	20	<p>7 FEB 2018: Proposal for alignment of work with improvement programmes completed and to be reviewed by Executive Management Team to initiate detailed work.</p> <p>9 JAN 2018: Benefits work initiated including alignment of work, data, and planning</p> <p>15 NOV 2017: Benefits realisation will now be planned.</p> <p>11 OCT 2017: EPR went live 23 Sep 2017.</p> <p>18 SEP 2017: No further update. To be updated three months post Go-Live.</p> <p>JUL 2017: Business case updated and submitted.</p> <p>MAY 2017: Benefit profiles and plans being updated for resubmission of FBC in July 2017.</p> <p>Update 3/1/17: Developing more detailed plans with the critical leads to ensure benefit realisation and identify potential additional benefits both financially and quality benefits.</p> <p>Risk being monitored through EPR Programme Board, EPR Transformation Board and EPR Operational Readiness Board which all have finance representation. There is also an EPR benefits lead for the programme who is undertaking a detailed review of the realisable benefits to assess viability.</p>	30/03/2018	Fedell, Cindy	20	10
2151	24/09/2013	Finance	Ongoing Risk - Annually: The requirement to maintain equilibrium between financial sustainability and delivering safe quality services is compromised by the economic challenge faced and the increasing internal and external demands to improve the quality and safety of the services provided.	Horner, Matthew	12	<p>DEC 2017: The exhaustion of the non recurrent measures places all the emphasis on delivery of the recurrent and sustainable initiatives within the improvement plan. To maintain the equilibrium it is imperative that a QIA & FIA complements all initiatives. Quick wins will be implemented immediately and for other initiatives where the relationship between the money, quality and safety may be compromised a risk based assessment will be undertaken based on the completed QIA and FIA.</p> <p>AUG 2017: With the financial plan currently being heavily supported in the short term by non recurrent measures, the requirement to source sustainable and recurrent savings plans has intensified and as such the importance of robust application of the approved QIA and FIA process has also intensified. The draft clinical strategy sets out the aspirations of the Foundation Trust, which will need to appropriately aligned to the Trusts financial planning parameters.</p> <p>APR 2017: Delivery of the control total requires the Trust to identify CIP's of £20.2m. A revised Quality Impact Assessment and Financial Impact Assessment process has been introduced for 2017/18, to ensure greater rigour is placed on the evaluation and implementation process for CIPs. It is recognised that wider challenges other than delivering CIPs (if not managed effectively) could impact on quality and the safe delivery of services. Where issues arise an informed decision will be taken that will include a quality and safety impact assessment.</p>	31/03/2018	Horner, Matthew	16	12

2236	21/01/2014	Informatics	Paper patient records are not accessible anywhere, anytime. Scanning backlog means that access to full information may not be available when and where needed delayed or impacting on care or treatment.	Fedell, Cindy	8	<p>7 Feb 2018: Operations are working on temporary additional resource to deal with backlog.</p> <p>Jan 2018: Transition to EPR and new Scanning Bureau has created a scanning backlog and issues accessing consent forms and other key clinical information that is on paper. Increased clinical risk. Divisions have been reminded of what/should and should not be in the mini-packs for scanning. Resourcing and other changes being made to reduce backlog. Trajectory being set.</p> <p>Dec 2017: Scanning backlog continues and is increasing. There is a risk with consent forms not being available when a patient presents for the procedure due to the backlog. This was raised at EPR Operational Meeting and an options appraisal has been produced. Awaiting information on the upgrade to the scanning software (Evolve) which will resolve some of the scanning issues. Due to the scanning backlog the current risk score has been increased.</p> <p>Nov 2017: Access to scanned documents in Evolve continues to be monitored- problems with messages resolved, however there is a scanning backlog which is being worked through currently. Monitoring the level of failed scans, working with the Directorate to ensure that these are visible to clinicians within Evolve.</p> <p>Oct 2017: Risk score reduced due to recent go-live of EPR. Still currently in early life support and so risk remains open to ensure that elements such as scanning of records and access to Evolve can be monitored to ensure working as planned.</p> <p>JUL 2017: EPR work continues on plan.</p>	31/07/2018	Pagan, Kay	16	4
2561	12/05/2015	Informatics	Recruiting and securing contractors in the Business Intelligence (formerly Corporate Information) difficult in the region. Reputation may be damaged and ability of operations and improvement work to manage may be hampered from lack of information.	Fedell, Cindy	16	<p>7 FEB 2018: Some vacancies being filled. A Change plan being developed and new job descriptions being drafted to reorganise team to improve recruitment. New Head of BI due to start 12/03/2018.</p> <p>9 JAN 2018: Proposed new structure produced and being reviewed with Finance. Change plan to be completed by the end of March 2018. Conditional offer made/accepted for head of service. Transition of tools (including EPR) and roles/responsibilities progressing.</p> <p>6 DEC 2017: Review of structure and job roles underway as posts remain difficult to fill. Recruitment activities continue.</p> <p>15 NOV 2017: Plans continue</p> <p>11 OCT 2017: Interim leadership arrangements remain in place as planned. Recruitment options actively being explored. New tools, in particular EPR, being incorporated into work, stabilising working practices.</p> <p>JUL 2017: Senior Informatics Consultant now in place to ensure successful delivery through EPR go-live. Review of team working and development needs being planned. Reporting Manager role re-advertised with interest expected.</p> <p>MAY 2017: Alternate leadership arrangements being made.</p>	30/04/2018	Hollings, David	16	6

3012	07/12/2016	Finance	Ongoing Risk - Annually: The Trust has insufficient cash & liquidity resources to sustainably support the underlying Income & Expenditure run rate	Horner, Matthew	16	<p>DEC 17: Delivery of the improvement plan will secure the planned cash and liquidity positions (albeit, risks have already been identified in the deliverability of the required value by 31.3.18). Delivery of the plan will be managed and monitored through the strengthened and extended performance management arrangements.</p> <p>AUG 17: The underlying income and expenditure run rate is adversely impacting on the Foundation Trusts Liquidity position. The improvement plan (currently under development) is targeted to improve the run rate and as such cease the downward trajectory in the liquidity position. A continuation of the current trend will require a range of alternative decisions to protect the cash and liquidity position (for example, deferring planned developments, deferring or stopping capital developments and management of the working capital position via the cash committee).</p> <p>APR 17: The financial plan submitted to NHSI produces a liquidity metric rating of 2 under the use of resources assessment. Liquidity falls to a negative 1 day by the end of the financial year which assumes the income & expenditure (I&E) plan, inclusive of 100% STF funding and the capital plan are delivered in full. Performance of the I&E position will be managed via Divisional Performance Reviews and budget meetings. The capital programme will be managed via the Capital Committee and the cash/liquidity position will be managed via the cash committee. Any adverse imbalance within the I&E position will negatively impact on the cash/liquidity position which will result in actions taken to curtail the commitment of cash (e.g curtailment of the capital programme or the commitment of revenue costs).</p> <p>The cash & liquidity position is managed and monitored by the cash committee with updates provided to the Finance & Investment Committee.</p> <p>Curtailment of the Capital programme in 2017/18 to limit the cash outlay</p> <p>Continued sourcing of cash releasing efficiencies</p> <p>Additional measures taken to improve financial control in the immediate and longer term</p>	31/03/2018	Horner, Matthew	16	6
3060	03/03/2017	Chief Nurse	<p>There is a high risk that patients with alert organisms will not be isolated or have other appropriate management leading to increased cross infection to others due to the lack of a fully functioning infection control reporting system.</p> <p>With previous lab arrangements with Leeds there was an automatic feed to the IPC surveillance and management software system ICNet. The feed has not been built prior to the change of microbiology lab to Airedale on 1st March 2017. Therefore the IPC team will have very poor information about alert organisms to ensure that correct IPC practices are in place.</p>	Dawber, Karen	20	<p>The risk will resolve once a reliable ICNet feed from Fordman is established</p> <p>Update May 2017: Near miss, regarding MRSA bacteraemia result. Need to rethink mitigation - urgent meeting with IT required.</p> <p>Update May 17: Unable to reboot system following shut down of IT systems - software is out of date and cannot be security patched.</p> <p>Update June 2017 - has been rebooted but Fordman link not operational</p> <p>September 2017 - Option appraisal completed by Dave G (IT) - with Director of informatics. Reports still not complete with Airedale, now asking for a report on every blood culture and ICT will filter. System embedded re MRSA and C diff</p> <p>December 17 update - agreed to procure update to existing system in Q4</p> <p>Business case signed off 16/1/18 - 3 month lead in time</p>	30/04/2018	Griffith, Dave	15	6

2157	24/09/2013	Finance	Ongoing Risk - Annually: Failure to deliver the obligations within the NHS standard acute contract will result in the application of financial penalties and/or the failure to recover planned income. This will include a failure to deliver specific indicators relating to specific targets/qualitative requirements and/or failure to deliver agreed indicators within the CQUIN schedule. The qualitative nature of the indicators will adversely impact on both the quality of services provided and the patient experience.	Horner, Matthew	8	<p>DEC 2017: The CQUIN steering group has been re-established in Q3 to monitor and manage delivery of the CQUIN indicators. Concerns regarding data quality (DQ) and performance against contract indicators (in particular the key access standards) has prompted the proposed re-introduction of monthly Contract Management Board meetings (currently running on an alternate month basis), to ensure full transparency is shared across all appropriate parties and to jointly resolve issues. The DQ issues are discussed and resolved at the data quality group (introduced following the implementation of EPR) and chaired by the interim Deputy Director of Operations.</p> <p>AUG 2017: The formalised contract management processes for 2017/18 are in operation with the appropriate levers/mechanisms being applied by both the provider and commissioner.</p> <p>APR 2017: All commissioner contracts have been agreed and signed for the financial year 2017/18, inclusive of the appropriate schedules and penalty regime. Performance against delivery of the various elements within the contract will be reported through the Divisional Performance Review and budget meetings. There is regular monitoring and performance management of the indicators and activity plans with in-built triggers both internally and externally through the commissioner contract reporting and meeting structures. Early discussions with the CCG's and NHSE highlighting risk areas and where necessary invoking the appropriate contract levers. Internal reporting and governance arrangements are in place for delivery and management of the CQUIN indicators with regular performance reporting to the Performance committee/Board of Directors identifying actions and mitigations.</p>	31/03/2018	Horner, Matthew	15	6
2908	03/05/2016	Chief Operating Officer	Ability to recruit and deploy adequate medical staff throughout the day to manage the demands of the Accident & Emergency Department	Shannon, Sandra	20	<p>Nov 2017: Continue to utilise middle grade locum medical staff to support the ED with senior decision makers out-of-hours. ANPs are also being sourced to support the department</p> <p>Aug 2017: Review of clinical staffing within the ED undertaken. Outcomes to be reviewed by Executive team in context of learning from other similar units and the other improvement measures being implemented.</p> <p>May 2017: Approved temporary additional staffing to support delivery of the emergency care standard and recruitment is ongoing.</p> <p>Feb 2017: Approved a plan to expand consultant and middle grade staff. Further demand and capacity model being worked up.</p>	31/01/2018	King, Susan	15	6

2991	21/10/2016	Informatics	EPR - Inability to fulfil contractual obligation in relation to information, reports, standards, etc following implementation of EPR. Loss of confidence in the Trust from other healthcare organisations leading to damage to organisational reputation.	Fedell, Cindy	12	<p>7 FEB 2018: RTT reporting testing underway and progressing to timescales, with the aim of submitting national RTT return in February 2018(for January data).</p> <p>9 JAN 2018 : RTT reporting issues are being resolved with EPR vendor. To be completed and tested beginning of February 2018.</p> <p>15 NOV 2017: Final reports nearing completion.</p> <p>11 OCT 2017: EPR went live 24 Sep 2017. DM01 report still in progress. Work on data quality post EPR in place.</p> <p>18 SEP 2017: Significant work has been completed to test and review the data flows from EPR through contract income, including acceptance by recipients. One report on the Diagnostic Target (DM01) is still in progress.</p> <p>Additional training has been completed, bespoke expert support, a swat team, and an updated Cymbio Data Quality Dashboard is in place to mitigate issues reporting. However data quality issues from other Trusts' go-lives indicate that data quality issues from data entry will occur and take time to correct and reduce, thus delaying accurate contract reporting.</p> <p>JUL 2017: Score updated due to lessons learned at CHFT. Work is underway to try and mitigate some of the issues experienced by CHFT.</p> <p>JUN 2017: Work continues to plan and a senior informatics consultant with EPR experience has been contracted to oversee.</p> <p>MAY 2017: Updated plans in place and being executed as per EPR Reporting Board and detailed review presented to Performance Committee. Update 13/02/17:</p>	28/02/2018	Hollings, David	15	6
3142	07/02/2017	Chief Operating Officer	<p>A structural survey and report was commissioned by E&F to determine the structural integrity of the floors of E Block. This was due to the amount of medical records stored in the building.</p> <p>The report has found that the floors are significantly understrength for the current usage of the building and recommends immediate structural repairs / works to support the floors. This will cost a significant amount of money and to do the works, records and staff need to vacate the building. The building is a listed building so permission would need to be sought from the Local Authority. Costs will be in the region of £200k.</p>	Shannon, Sandra	15	<p>February 2018: Business Case is will be presented to the next Business Case Review meeting.</p> <p>October 2017: Business Case to be produced</p> <p>The best and safest solution is to vacate the building, however space needs to be found to house the current notes</p> <ul style="list-style-type: none"> •Paper produced & discussions held with Execs, scoping exercise to be carried out to determine what is required. •Paper produced. Several properties found in local area available for rent which will house E Block records – communicated to execs. •Further advised to devise a longer term plan to move all records off site. <p>E&F concerned that potential structural issues remain - to be discussed at CRAG.</p>	31/05/2018	Featherstone, Paul	15	2
3150	06/10/2017	Chief Operating Officer	Financial penalties and reputational impact in the failure to deliver 90% performance against Emergency Care Standard	Shannon, Sandra	16	<p>Full governance structure surrounding the improvement plan with escalation to the Chief Executive.</p> <p>6/2/18. The DCD is currently providing focused support to urgent care. The Acting CoO has reviewed the improvement plan to provide direction and drive in taking forward improvements.</p> <p>additional management support provided to the department.</p> <p>A business case has been approved for a new consultant post - Director of urgent care to provide senior leadership across the whole urgent care pathway</p>	01/05/2018	Wilson, Dr Brad	15	12

3188	19/12/2017	Chief Nurse	There is a risk that post implementation of EPR staff are not complying with the necessary recording of high impact interventions, risk assessments and individualised care plans in the EPR. This will result in a lack of complete documentation and may pose a clinical risk to patients	Dawber, Karen	15	Our audits and manual checking processes are showing that staff are not adequately recording VIP scores, cannula insertion and other HII in the EPR. A PROGRESS review has shown that individualised care plans are not being completed also. Work on-going to raise awareness but will need a further campaign to embed practice throughout all of the wards and departments. In the interim we continue to monitor harms associated with the HII - we are not seeing any statistically significant changes, this would indicate that this is a recording rather than poor clinical practice issue.	30/06/2018	Scales, Ms Sally	15	6
3192	08/01/2018	Chief Nurse	There is a risk that the new guidance on the Mental Health Act (December 2017), in particular section 136, may result in uncertainty in determining who has a duty of care to the person subject to such an order. This may result in the Trust failing to fulfil its duties in line with the mental health act. Note - A section 136 allows a police constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 24 hours.	Dawber, Karen	15	Task finish group to be led by Sarah Turner to meet with partners and agree consensus of opinion. This will then lead to training being put in place for AED and other staff. If the above cannot be completed by target date then this will be raised by the Chief Nurse at the Safeguarding Adults Board	31/03/2018	Scales, Ms Sally	15	6
3211	07/02/2018	Chief Operating Officer	There is a risk to patient safety from not delivering the national standards for cancer patients. Discussed at IGRC 15.1.18 agreed to be added to CRR.	Shannon, Sandra	15	February 2018: High level Cancer recovery Plan agreed with NHSI. Established patient level tracking and escalation plans. Discussed at IGRC 15.1.18 agreed to be added to CRR.	30/04/2018	Jones, Laura	15	6
3184	03/01/2018	Medical Director's Office	There is a risk that patients are not being assessed for VTE and thereby at risk of hospital acquired VTE.	Gill, Bryan	12	February 2018 - Work undertaken to communicate and share daily VTE (patient-level) reports. Completed revisions to 80% of cohort rules. Working with CHFT to standardise the cohorts. Further work required to target the small number of ward areas who are failing to meet the standard. Meetings set up. Achieving circa 92% performance. October 17 - Detailed action plan developed. Task and finish group set up to monitor weekly compliance. Working with CHFT on cohort rules given single EPR. Direct communication taken place to specialty leads for all failing areas.	30/03/2018	Smith, Dr Paul	12	6
1739	23/11/2012	Division of Governance and Corporate Affairs	Risk to Patients and staff due to staff using medical devices inappropriately.	Thompson, Donna	12	Feb 2018: Task and Finish Group has been established to report back to EMT by end of April 2018 with recommendations. Aug 2017: Process is in place for new medical equipment entering the Trust which ensures adequate training is undertaken prior to use. Proposal being drawn up by Clinical Engineering to address medical equipment in use.	31/05/2018	Threlkeld, Iain	12	4

2146	24/09/2013	Medical Director's Office	Risk of adequate procedures relating to safer surgery not being in place within a service leading to patient harm	Gill, Bryan	15	<p>January 2018: Recent snapshot audit shows ongoing challenges in delivery of consistent safer procedure process. A review of actions to take place following the Quality Summit on the 19/01/2018. Risk score adjusted to reflect assurance level.</p> <p>December 2017-Update paper taken to Quality Committee 29/11/2017.</p> <p>to provide update on the work undertaken to meet the standards this includes:1]The BradSSIP Implementation Group revised and approved the Safe Procedures Policy 2]BradSSIP to ensure compliance with NatSSIPs and to set the standard for Bradford 3]Handbook has been produced, with engagement from staff undertaking invasive procedures, to summarise the standards for staff 4]An overview of BradSSIPs has been presented at the Senior Leader Forum to raise awareness of BradSSIPs 5]Members of the BradSSIPs Implementation Group have attended Clinical Governance sessions and Team meetings to raise awareness of BradSSIPs and request working parties are established to develop plans to improve compliance 6]Developed local Standard Operating Procedures 7] Collaboration with Calderdale and Huddersfield's Implementation Group to share learning, knowledge and progress.</p> <p>April 17-The Trust's Safer Procedure Policy has been revised to meet the NATSSIP standards. Multidisciplinary team members from across BTHFT are collaborating to develop our own local safety standards for invasive procedures which will be known as BradSSIPs and are based on the five steps to safer surgery, procedural steps and organisational steps in the patient journey. Each Division has been asked to establish a working group by the end of June 2017 to:</p> <ul style="list-style-type: none"> *Identify all relevant invasive procedures within the Division *Map existing SOP's/Policies against BradSSIP standards to identify any gaps. * For invasive procedures that have identified gaps develop standardised SOP's *Harmonise to BradSSIPs *Educate all staff in the safety standards, SOP's using all methods especially training in human factors, team working and simulations. 	30/04/2018	Bellerby, John	12	6
2683	02/12/2015	Division of Governance and Corporate Affairs	Risk of action against the foundation trust resulting from the quality of external data submissions.	Thompson, Donna	12	<p>Aug 2017: Paper received at EMT describing the measures in place to mitigate the risk. This includes a task & finish group being formed and linking to existing committees, a review of external data submissions will be undertaken to review quality and impact.</p> <p>April 2017: Planned discussion at EMT following review of national audit requirements.</p>	30/03/2018	Claridge, Tanya	12	4
2841	24/03/2016	Chief Operating Officer	Potential of prosecution due to poor segregation and contamination of waste across the organisation	Shannon, Sandra	16	<p>7/2/18 a number of actions have been completed including training, SOPs and policy updates.</p> <p>Action plan in progress Jan 18: TOR written for waste group</p> <p>Internal audit report received and action plan being followed</p> <p>Dec 17: New waste rooms completed in ENT block, allowing good segregation of waste.</p> <p>Offensive and medicinal waste rolled out on BRI site, within limitations set by Infection Control</p> <p>Aug 2017: Continued compliance with action plan. Outstanding requirements to be completed by Oct 2017. Staff understanding of the requirements for waste segregation remain a concern. Training to be revisited.</p> <p>April 2017: Action plan implementation ongoing</p>	30/04/2018	Keasey, Charlotte	12	6

2417	16/09/2014	Medical Director's Office	Risk of patient harm due to diagnostic tests not all being reviewed and acted upon in a timely manner	Gill, Bryan	15	December 2017: Following the implementation of EPR there are some areas including Radiology where there is a direct link for results to be accessed by clinicians and a workflow to provide prioritisation of results but in other diagnostic areas this is still not available and work is continuing to ensure that there is a seamless system throughout. Final phase of linkage to pathology results due in January 2018. June 2017: There remain a small number of diagnostic test results in which there is a delay in dealing with the result. The risk will be mitigated further following the implementation of EPR as this will demonstrate which results have not been reviewed and allow an escalation procedure to be enacted.	29/06/2018	Elliott, Dr Leeanne	12	12
3068	15/03/2017	Division of Governance and Corporate Affairs	The Trust is non-complaint with the Carriage of Dangerous Goods	Thompson, Donna	12	February 2018: Report and action plan to be discussed at H&S Committee in March 2018. Jan 2018:Independent audit carried out and Assessor report received in December. Report and assessment of outstanding risks with revised action plan to be discussed at Estates Risk Group end Jan 2018. Internal Audit review to be undertaken within 2017/18. Aug 2017: A task & finish group has been set up with ToR and reporting to the H&S Committee. An action plan to address the areas of non-compliance is being managed by the group. A further audit will be undertaken by an external competent person in November 2017. A task and finish group is being set up to deliver an action plan to implement the appropriate remedial action.	30/04/2018	Wilson, Craig	12	6
3091	24/04/2017	Strategy and Integration	There is a risk that decisions of the West Yorkshire & Harrogate Health & Care Partnerships (previously the "Sustainability & Transformation Plan/Partnership" (STP)), lead to enforced actions (e.g changes in pathways of care or consolidation of support services) which the Board might consider are not in the best interests of the local patient population or which could create clinical, financial, operational or other regulatory difficulties for BTHFT, including the ability to deliver CIPs and meet control totals.	Holden, John	12	February 2018: WYHP has now formed a "System Leadership Exec Group" (SLEG) and is developing an MOU to address questions about its governance, in readiness for a proposed expression of interest to the national ALBs to enable WYHP to become an "Integrated Care System". BTHFT attends the SLEG and will stipulate the tests our Board requires to be met before we can support the expression of interest. NB: given uncertainty about current WYHP governance model it is not clear whether an expression of interest could go forward without unanimous support. November 2017: Continued participation in collaborative work e.g proposed development of a WY-wide clinical strategy (to improve prospects of attracting national capital funds). Acute collab programme with Airedale FT progressing; plans for clinical summit. September 2017: Publication of refreshed BTHFT clinical services strategy setting out clear direction of travel and new, clarified vision & strategic objectives. Head of Policy appointed with clear focus on acute collaboration, to manage risks, coordinate activity and exploit opportunities July 2017: Clarified and improved tracking of variety of WYAAT & STP projects; discussed regularly by Execs in new dedicated EMT "partnerships" sessions	02/04/2018	Holden, John	12	8

3110	26/06/2017	Medical Director's Office	Following the successful formation of the new Pathology service (IPS Ltd) with Airedale hospital from January - March 2017, risk has now changed to the ability to maintain an effective pathology service.	Gill, Bryan	12	January 2018: Turn around times in microbiology demonstrate meeting standards. Small number of clinical concerns are being addressed through newly formed operational and governance groups of the JV. Planned meeting with MD and ID consultants taking place in January. Locum microbiologist in place at BTHFT. October 2017: performance improved with turn around times in line with expectation. Outstanding issues in microbiology and serology being worked through with relevant clinical services. August 2017-Number of Datix incidents showing signs of failing, ongoing challenges remain in Microbiology. IPS working with clinicians to resolve concerns regarding turnaround times. Bi- weekly safety meetings taking place. Overall impression service has stabilised. June 2017: Governance systems have become operational with IPS Board and Operational group. Recruitment of Managing Director and Clinical Director in the last 2 months. Workload challenges in Microbiology have required an increase in Laboratory Staff adding risk and costs to the Joint Venture Partnership. Significant engagement activities taking place with all staff groups across the Trust. Ongoing issues being slowly resolved but some outstanding issues remain in relation to turn around times for some specialities. Biweekly safety meetings taking place.	30/03/2018	Elliott, Dr Leeanne	12	4
3134	17/08/2017	Chief Nurse	There is a risk that sharps are not being disposed of correctly leading to a potential for patient and staff harm due to needle stick injuries	Dawber, Karen	12	Sharps Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee December 2017 Update - group continues to meet, with targeted interventions. There has been some improvement but this has been hampered by changes in personnel with the frontier (Bin Manufacturers) around training. Video available for staff and being picked up on sweeper. Reporting to Quality and Safety sub committee by except	31/03/2018	Franklin, Sue	12	6
3013	07/12/2016	Informatics	There is an increased risk of cyber security attacks to healthcare organisations. Health records and healthcare providers are at risk of cyber attack as demonstrated in recent examples. This could potentially cripple the clinical and business operations of the Trust.	Fedell, Cindy	20	7 FEB 2018: Preparation underway for additional external cyber reviews. 8 JAN 2018: Cyber security arrangements and reporting under continual review. 6 DEC 2017: Software security patching process working well. Regular compliance reporting in place. 15 NOV 2017: No new incidents. Cyber protection work continues on plan with full compliance to the NHS Digital CareCert Scheme updates. 11 OCT 2017: No new incidents. SEP 2017: Revised arrangements in place and continuing to ensure functioning well. JUN 2017: Expedited patching process approved and in place. MAY 2017: Review and updating of cyber protection as needed. MAR 2017: External security assessment reviews completed.	30/03/2018	Scott, Ian	12	12

3046	03/02/2017	Informatics	Since the 2010 the enterprise agreement with licensing bodies which was paid for centrally has been devolved to Trust level. The financial risk is considerable and lies with the Trust.	Fedell, Cindy	8	7 FEB 2018: All known licensing issues addressed from devolution of licenses. Review of new software implementations being undertaken. 9 JAN 2018: Agreement reached with software vendor and order placed to correct licensing position. Audit closed. 6 DEC 2017: Negotiations with software vendor nearing conclusion with all efforts to minimise financial impact. 15 Nov 2017: Work continues. 11 OCT 2017: External specialist engaged and reviewing positions. Options via NHS Digital are being explored. JUL 2017: External specialist selected. JUN 2017: Engaged with licensing specialists to review position and recommend license model changes if necessary or negotiate with supplier. MAY 2017: Engaged with licensing specialists. Previous: Liaise with central government bodies for assurance we have the correct licensing in place.	30/03/2018	Hollings, David	12	6
3047	06/02/2017	Informatics	The Pathology Joint Venture is using a Pathology Laboratory Information Management System (LIM) that is only used at one other site, is not well supported by the supplier and the primary support from Airedale is via two people, only one who has significant knowledge of the system. This could impact accessibility of LIM and recovery from any issues.	Fedell, Cindy	12	9 JAN 2018: Pathology Joint Venture currently assessing options for LIM replacement. Pre procurement discussions with suppliers ongoing. 15 NOV 2017: Plans progressing. 11 OCT 2017: Planning team formed to progress. JUL 2017: Demo completed and feedback session being scheduled. JUN 2017: Replacement work started with demo of a leading pathologist information system supplier scheduled in June 2017. Additional resources in place. Basic business continuity plans in place.	31/12/2019	Griffith, Dave	12	4
3050	13/02/2017	Chief Nurse	There is a risk to that women will not receive the correct level of 1 to 1 care in labour due to theatre staffing levels on labour ward. Historically we have only staffed theatres during the day with dedicated scrub staff. This means that in the event of an emergency and planned list or 2 emergencies lists midwives would be expected to scrub, depleting the numbers on the shop floor.	Dawber, Karen	12	On going discussions with surgery to look at a different model Re run of BRP commencing February 2017 for 3 month period Review of out of hours theatres across Trust Main theatre on call to help when emergency maternity theatres running. Staff being recruited too, business case agreed Dec 17 - difficulties in recruitment, trying to recruit M/ Wives not ODP in Q4	31/03/2018	Wright, Dr Janet B	12	6