

Report from the Integrated Governance & Risk Committee (IGRC) Held on 24 April 2018

Presented by:	Professor Clive Kay, Chief Executive	Author:	Sheridan Osbourne, Corporate Governance Officer
Previously considered by:	Integrated Governance & Risk Committee 24 April 2018		

Key points/ Executive Summary	Purpose:
1. Corporate Risk Register – New Risks added No new risks have been added during April 2018.	To note and gain assurance
2. Corporate Risk Register – Risks that have changed in Score One risk has changed in score during April 2018. The details can be found on page 1 of the attached Corporate Risk Register Movement Log.	To note and gain assurance
3. Corporate Risk Register – Risks Removed or Closed Thirteen risks have been closed during April 2018. The details can be found on pages 2 of the attached Corporate Risk Register Movement Log.	To note and gain assurance
4. Divisional risks escalated to the Corporate Risk Register - None escalated during April 2018	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 24 April 2018 is attached.	To note and gain assurance

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

Corporate Risk Register Movement Log

Report date	19/04/2018
Prepared by	Sheridan Osbourne
Prepared for	IGRC 24.4.18

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)
			None to report							

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
2968	Jul-16	Chief Operating Officer	Risk of delivery of Trust-wide Microbiology Service due to inability to recruit to Consultant Microbiologist posts, retirement Dr Campbell (2015) and Dr Hasnie leaving Sept 2016.	Shannon, Sandra	12	<p>17/4/18 recruitment of outstanding vacancy in process. Outsourcing continues.</p> <p>7/2/18 One of the consultant vacancies has been appointed to, which leaves 1 WTE vacancy. The service continues to outsource to fill the capacity gap. Alternative workforce models are also being considered in the longer term.</p> <p>Nov 2017: The risk continues to be managed with existing mitigation plans in place</p> <p>Aug 2017: ID consultants together with locum providing service. Recent advertisement did not generate any interest so the Trust will advertise again jointly with AGH.</p> <p>Feb 2017: Appointed new microbiologist. Retired microbiologist providing temp support</p> <p>Control Measures planned: Increase existing Infectious Disease Consultant Physician's PA's by 0.5 and review options for Agency within cap and working collaboratively with Airedale Microbiologists to join the OOH & on-call rota's.</p> <p>There is an agreement to go out to joint recruitment between AGH & BTHFT for 2 Consultant Microbiologist posts in August 2016.</p> <p>Only adequate if all elements are achieved</p>	30/03/2018	Cunningham, Collette	6	9

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
3216	23/02/2018	Finance	The risk that the inability to accurately report the Trusts activity and income position is compromising the quantification of the 17/18 income forecast and establishing a robust baseline for the 18/19 contract. This limits the trusts ability to recover an appropriate amount of income for 17/18 and prevents a pragmatic discussions with Commissioners around proposed counting and coding changes and the overarching payment mechanism for 18/19.	Shannon, Sandra	16	17/4/18 The data quality and income recovery plan continues to be implemented. In addition, activity recovery plans have been developed for all services based on agreed contract SLA and demand and capacity modelling. These will be implemented by the end of April 18. al Prioritisation of Master plan with focus on key Data Quality and build issues. Detailed training programme required to correct input errors at source. Agreed resource profile required to correct backlog and secure sustainable position. Continued discussions with Commissioners regarding the validity of current 17/18 income forecasts and commencement of negotiations for 18/19 contract agreements. Extended communication and engagement with Commissioners in the delivery of the master plan to maintain relationships and provide assurance. The action plan will be managed by the newly proposed governance arrangements.	30/03/2018	Shannon, Sandra	16	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	13/3/18 - the medical workforce paper will be completed in March. 12/2/18. The 3 associates specialist will remain on the consultant rota. There is still a requirement to review the medical workforce paper. The department has 6 trainee ACP's of which 2 posts will be offered as permanent positions on completion of the training programme. 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 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.	31/01/2018	King, Susan	12	4
1732	07/11/2012	Informatics	Certain IT systems & functions may not be fit for purpose, particularly data quality.	Fedell, Cindy	16	14 MAR 2018: Expanded data quality team in place, seconded to the COO. 07 FEB 2018: Data quality monitoring specifically related to patient administrative pathways continues with weekly monitoring. Data quality tactical plan to progress beyond current state drafted and being vetted for review by the Executive Management Team. 09 JAN 2018: New Data quality plan drafted and expected to be reviewed by Executive in Jan 2018 to leverage good work being done with EPR data quality. 15 Nov 2017: Work is progressing under operational leadership. 11 OCT 2017: EPR went live 24 Sep 2017, streamlining most data flows. Updated Cymio Data Quality Dashboard and operational management in place. JUN 2017: Improvement work continuing with data warehouse and transition to EPR, including updated standard operating procedures to enable improvement and updated ongoing monitoring tools and process.	29/06/2018	Hollings, David	9	6
2497	13/01/2015	Informatics	Risk of information governance breaches and action being taken by the Information Commissioner	Fedell, Cindy	12	14 MAR 2018: IG toolkit compliance on track for the end of March 2018, including IG Training compliance with target. 8 FEB 2018: Each division actively resolving outstanding training. Information Commissioners Office Best Practice recommendations implemented with a favourable audit from Internal Auditors. IG Toolkit progressing on plan. Improvements related to General Data Protection Regulation progressing. 6 DEC 2017: Further additional IG Training sessions in place to ensure maximum compliance. 15 Nov 2017: Statistics being verified for circulation of outstanding list to divisions in Nov 2017. Sessions being scheduled. 11 OCT 2017: IG training completed with EPR (94% of EPR-related staff). Statistics being reviewed at Oct 2017 Sub-Committee meeting to determine position and possible next steps. JUL 2017: IG training included in EPR training.	30/03/2018	Fedell, Cindy	9	12
3164	14/11/2017	Chief Operating Officer	The Trust received notification that Bradford was showing as an outlier for Stroke mortality data. When this was investigated it showed that inaccurate and incomplete data had been submitted via the SSNAP site which is a National Audit for the care and treatment of stroke patients. This data had not been validated nor signed off by the Trust prior to submission	Shannon, Sandra	20	06/03/2018 - BTHFT SSNAP data for the period August-November 2017 shows deterioration to a Level E (from previous D). A comprehensive improvement programme has now been put in place to drive a sustainable improvement in the Stroke Service. A report on the Quality of care provided by the Stroke Service was presented to the Quality Committee on the 28.02.2018 to provide assurance on the quality of care provided by the Stroke Service. 7/2/18. Data sources for all data fields have been identified and agreed. Multidisciplinary team involved with data entry and validation SSNAP team visit to be organised for early 2018 For the 4 month period August to November 100% of the data has now been input. The backlog to April has also been input with the exception of approx. 10-12 patients that are being sourced.	01/11/2017	Bannister, Ann	6	1

CRR risks 12 and over

Open Corporate Risks with a Current Rating >=12 Grouped by Principal Risk

ID	Date of entry	Risk Lead	Source of risk	Description	Next review date	Likelihood (initial)	Consequence (initial)	Risk Level (initial)	Likelihood (current)	Consequence (current)	Risk level (current)	Existing control measures	Summary of risk treatment plan/mitigation	Target date for implementation of mitigation	Risk Level (residual)
Principal risks: 1. Failure to maintain the quality of patient services															
3211	07/02/2018	Shannon, Sandra	National Target	There is a risk to patient safety from not delivering the national standards for cancer patients. Discussed at IGRIC 15.1.18 agreed to be added to CRR.	15/05/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Comply with national reporting requirements externally. Reporting in place through Divisional Performance Review and Finance & Performance Committee to Board of Directors.	17/4/18 The cancer improvement plan continues to be implemented. Specially specific action plans have also been developed. Focus is on reduction of 62 day backlog and clinical harm review of all long waiting patients. Additional tracking staff are being sourced. March 18. Cancer improvement plan being implemented. Robust governance in place to review weekly. February 2018: High level Cancer recovery Plan agreed with NHS. Established patient level tracking and escalation plans. Discussed at IGRIC 15.1.18 agreed to be added to CRR.	30/04/2018	Moderate
3222	14/03/2018	Gill, Bryan	External Bodies	In February 2018 the Trust received notification that the latest National Sentinel Stroke Audit Programme (SSNAP) performance demonstrated an unexpected deterioration to level E. Following a series of detailed discussions with the service and the Executive team it was decided that immediate action was required to improve the provision of Stroke Care.	30/04/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Following a series of detailed discussions the following actions were agreed and implemented. 1) A weekly Stroke Service Improvement Group convened, chaired by the Medical Director. 2) A detailed action plan produced for both immediate and long term improvements.	17/04/2018 Following meeting on the 11/04/2018 - two main areas of work agreed. 1) Quality of Service, Executive Lead Medical Director 2) Operational issues, Executive Lead Chief Operating Officer reviewing short, medium and long term challenges for the service. Agreed one action plan for the service including both areas of work. The plan in place to improve the delivery of a quality service for stroke patients (including recovery in the SSNAP performance) includes: 1) Monitoring & Improvement [Weekly Stroke Improvement Group & QI programme] 2) Service Review 3) Data validation including daily real time reports of key SSNAP standards 4) Team development linked to the service review 5) Regular reporting and assurance to: Quality Committee, Closed Board, EMT and external organisations through normal	31/03/2019	Moderate
3188	19/12/2017	Dawber, Karen	Infection Control	There is a risk that post implementation of EPR staff are not complying with the necessary recording of high impact interventions (HII), 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	31/05/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Infection control audits are in place. However, there are some issues with this see previous risk. Ward sisters use care compass to navigate what is outstanding however, potentially if a care plan has not been requested this may not always be visible. There is an inconsistency in how care plans are requested and generated - this needs further embedding as we continue to implement the EPR	Our audits and manual checking processes are showing that staff are not adequately recording cannula 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	Moderate
2236	21/01/2014	Fedell, Cindy	Risk Management Steering Group	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.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(2) Minor	8	(4) Will probably recur, but is not a persistent issue	(4) Major	16	In May 2015 the clinical portal was extended to now include all letters and A&D CAS Cards, representing a broader collation of clinical information available in Evolve in addition to existing Discharge Summaries.	16 Apr 2018: Upgrade to scanning software completed. Scanning Bureau resources are being kept under review. 13 Mar 2018: Operations continue to monitor backlog and identify resources as required. 7 Feb 2018: Operations are working on temporary additional resource to deal with backlog. 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. 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)	31/07/2018	Moderate

3184	03/01/2018	Gill, Bryan	National Target	There is a risk that patients are not being assessed for VTE and thereby at risk of hospital acquired VTE.	30/04/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>The Trust has consistently failed to meet the 95% compliance target for VTE assessment following the introduction of a new system in 2016. The EPR was expected to improve the system for undertaking and monitoring the meeting of this standard but as yet has not been realised. Data became available at the end of November 17 which demonstrated 60% of areas were meeting the target. The 40% not doing so have issues of staff compliance, cohort rules and use of the EPR. Work has started to improve compliance at ward level and being monitored weekly initially and daily where compliance does not improve.</p>	<p>April 2018: Full update paper presented at Quality Committee (Q3.18.15). Continued progress at 94.5%. Outstanding work on high throughput areas and cohorting rules.</p> <p>March 2018: Rate for February 2018 93.95%, on trajectory to meet 95% standard by 31/03/2018. Update on comprehensive improvement to be presented and discussed at Quality Committee on the 28/03/2018.</p> <p>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.</p> <p>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</p>	30/04/2018	Moderate
3134	17/08/2017	Dawber, Karen	Risk Assessment	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	30/04/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Sharps Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee</p>	<p>Sharps injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee</p> <p>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.</p> <p>Video available for staff and being picked up on sweeper.</p> <p>Reporting to Quality and Safety sub committee by excepti</p>	30/04/2018	Moderate
3017	09/12/2016	Claridge, Tanya	Risk Assessment	There is a risk that patients and staff may come to harm as a result of inadequate measures in place to assess and mitigate moving and handling risks. There is a reputational risk to the Trust due to non-compliance with legislation There is a financial risk from claims due to inadequate measures in place	30/04/2018	(3) May recur occasionally	(3) Moderate	9	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Staff training sessions available. Key trainers in place. Lifting aids available.</p>	<p>April 2018: A member of staff seconded to the risk team from the moving and handling team has moved back to her original post managing the team. Their hours have been supplemented by 0.2NTE within existing risk budget, in addition the hours of one of the other established post (to become vacant due to retirement) have been supplemented by 0.1 WTE within existing risk budget. The funding for the business case has not yet been identified March 2018: Funding is being identified to enable the business case to be approved February 2018: Temporary resource is being directed to support patient lifting & handling. A risk assessment is being completed.</p> <p>November 2017: Funding is not recognised in the nursing review for key trainers so the business case requires £104K funding which has been declined. Paper outlining concerns has been developed for the next Integrated Governance and Risk meeting.</p> <p>October 2017: A business case is being developed which is expected to be cost neutral</p> <p>June 2017: outcome and proposals</p>	30/04/2018	Moderate
1739	01/08/2017	Claridge, Tanya	Escalated from Division	Risk to Patients and staff due to staff using medical devices inappropriately.	31/05/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Process in place for new medical equipment entering the Trust to ensure adequate training is undertaken prior to use.</p>	<p>Feb 2018: Task and Finish Group has been established to report back to EMT by end of April 2018 with recommendations.</p> <p>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.</p>	31/05/2018	Moderate

3047	06/02/2017	Fedell, Cindy	Trust Wide Risk	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.	29/06/2018	(3) May recur occasionally	(4) Major	12	(3) May recur occasionally	(4) Major	12	Careful attention to support on call schedule, cross-skilling, and documentation. Business continuity plans.	16 APR 2018: LIM options appraisal activities on-going. 14 MAR 2018: Options appraisal on-going. 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. MAR 2017: Secondary resource in place and being trained, including instructions on how to restart any of the interfaces provided to IT and instructions on how to reboot the system provided to IT. Planning on a system reboot test and on a regular basis (timeline currently under discussion). Remote viewer will be developed to allow a fail back system should the ICE (results viewer) link fail. Fullscope business	31/12/2019	Moderate
3013	07/12/2016	Fedell, Cindy	Business Continuity	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.	31/08/2018	(4) Will probably recur, but is not a persistent issue	(5) Catastrophic	20	(3) May recur occasionally	(4) Major	12	Current firewall. Engagement with NHS Digital CareCert scheme in order to undertake external security assessment and give report and recommendations. Regular security penetration testing undertaken as part of annual Information Governance plan.	16 APR 2018: Annual cyber review completed. Detailed work plan for this year being finalised alongside the development of a cyber strategy. 14 MAR 2018: Internal review of cyber controls completed in advance of further external planned reviews. 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.	31/03/2019	High
2417	16/09/2014	Gill, Bryan	Governance and Risk Committee	Risk of patient harm due to diagnostic tests not all being reviewed and acted upon in a timely manner	29/06/2018	(3) May recur occasionally	(5) Catastrophic	15	(3) May recur occasionally	(4) Major	12	NOV 2015: The 10 recommendations proposed by the Task and Finish Group have been circulated to the Deputy Divisional Clinical Directors for discussion at the Specialty Governance meeting. Assurance on local failsafe mechanisms in place is required in lieu of an electronic solution. The Associate Medical Director (Informatics) is developing a secure email facility at specialty level. This is an agenda item for the Patient Safety Committee 19/11/15 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	29/06/2018	High	

2146	24/09/2013	Gill, Bryan	Corporate Objective	Risk of adequate procedures relating to safer surgery not being in place within a service leading to patient harm	30/04/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	SEPT 15: There is a planned re-launch of the Safer Procedure workstream in line with the publication of the NPSA Alert - National Safety Standards for Invasive Procedures (NatSSIPs). This will be a collaborative piece of work between the Quality Improvement Department and the Improvement Academy with support from NHS QUEST. Data risk No 2147 closed Sept 15 and merged with this risk.	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. December 2017: Update paper taken to Quality Committee 29/11/2017, 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	30/04/2018	Moderate
3050	11/02/2017	Dawber, Karen	Escalated from Division	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 lots of midwives would be expected to scrub, depleting the numbers on the shop floor.	31/05/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Recruitment in process Main theatre on call to help when emergency maternity theatres running. paper presented to EMT June 2017, await BIP Theatre staffing approved, recruitment in place / waiting for starters	On going discussions with surgery to look at 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 to, business case agreed Dec 17 - difficulties in recruitment, trying to recruit M/ Wives not ODP in Q4 March - continue with recruitment campaign, mitigation date extended to 30/6/18. 2 x band 7 on each shift, some use of agency staff and small amount of permanent staff for elective lists	30/06/2018	Moderate
3221	13/03/2018	Claridge, Tanya	CQC Visit	There is a risk that patients will not receive safe and effective pre-, peri- and post-operative care in our theatres	29/06/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Line management arrangements in place with clear lines of responsibility and accountability SOPs in place	March 2018: A Quality Summit process is in place with a plan to holistically review the service and make improvements to service delivery and patient care GE Finnmore and BTHFT OD are supporting staff Environmental checks and modifications have been undertaken by Estates Regular joint operational and estates meetings are in place A formal action plan is in place, encompassing the transactional estates and IPC improvements required together with organisational development and other service level improvements	30/11/2018	Low
Principal risks: 3. Failure to maintain operational performance															
3150	06/10/2017	Shannon, Sandra	Trust Wide Risk	Financial penalties and reputational impact in the failure to deliver 90% performance against Emergency Care Standard	15/05/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	16	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	ECS Improvement programme in place reporting to the Trust Improvement Committee .	April 18 The ECS improvement plan continues to be implemented. ECS performance has improved over the last month. Focus continues on improving patient flow within ED and across the trust. March 18. Additional senior management support is in place to support the improvement programme. 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 Coe 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	High

3215	23/02/2018	Shannon, Sandra	Escalated from Governance Committee	The risk that the inability to accurately report and allocate activity to correct Points of Delivery in 17/18 will invalidate the 17/18 reference cost submission and compromise the effective use of PUCs/SLR information in 18/19	15/05/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	The master plan of all outstanding EPR data quality and system build issues being collated. Resource requirements and timescales not as yet formalised/agreed. Establish appropriate governance structure to manage delivery of actions.	17/4/18 Implementation of the recovery plan continues. The focus is on identifying the cause of data quality errors, training staff on correct processes and correction of retrospective data. A monthly reconciliation process continues. The end of year March 2018. A central recovery team has now been established. Full governance framework around the recovery plan with escalation to COO. Prioritisation of Master plan with focus on key Data Quality and build issues. Detailed training programme required to correct input errors at source. Agreed resource profile required to correct backlog and secure sustainable position. Establish appropriate governance structure to manage delivery of actions.	29/06/2018	Moderate
2683	02/12/2015	Claridge, Tanya	Escalated from Integrated Risk Register Review Meeting	There is a risk that poor quality of external data submissions (including national clinical audit) will result in action against the Trust	30/03/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	There are a variety of systems in place through informatics and other teams to understand the quality of data submissions. This does not extend to all data submissions	April 2018 Data Quality Control measures have now been put in place for a number of national clinical audits. However these measures are generally invested in an individual or a key process that are relatively fragile (ie depend on an individual member of staff). As a result close monitoring of case ascertainment and quality issues is required. In addition a review has been undertaken of the impact of EPR on the quality of national audit submissions whilst the automation of some data will yield huge benefits, risks to data quality in relation to paper dependent processes and the reliability of scanning those documents in. This is subject to a separate risk assessment which is underway, the mitigation for the original risk is in place, changing circumstances has meant that this mitigation requires a review as part of a full reassessment of this risk. Aug 2017: Paper received at EMT describing the measures in place to mitigate the risk. This includes a task & finish group being formed	30/03/2018	Moderate
Principal risks: 4. Failure to maintain financial stability															
3012	07/12/2016	Horner, Matthew	Trust Wide Risk	Ongoing Risk - Annually: The Trust has insufficient cash & liquidity resources to sustainably support the underlying Income & Expenditure run rate	31/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	The cash & liquidity position is managed and monitored by the cash committee with updates provided to the Finance & Performance Committee. Curtailment of the Capital programme in 2017/18 to limit the cash outlay Continued sourcing of cash releasing efficiencies Additional measures taken to improve financial control in the immediate and longer term	APR 18: The Trust ended the financial year with a liquidity rating of 2 with circa £25m of cash which was behind plan as a result of the non-recurrent measures deployed throughout the year. The CIP required for 18/19 to meet the control total is significant and places a significant risk on maintaining a sustainable cash and liquidity position. The newly introduced Bradford Improvement Programme with updated and strengthened governance and accountability arrangements will measure and monitor delivery of the CIP plan. To protect the cash position the capital programme may also have to be curtailed FEB 18: Whilst on trajectory against the improvement plan from an Income and Expenditure perspective, the continued use of non-recurrent measures is impacting directly on the cash position, resulting in a deterioration of the liquidity position. Recurrent CIP's need to be identified to protect the cash position and deliver the pre STF control total. Failure to do so will impact on the planned cash position by £6m as a result of not recovering Q3 & Q4 STF incentive funding. The cash committee	31/03/2018	Moderate
2893	19/06/2016	Fedell, Cindy	Trust Wide Risk	EPR - inability to achieve the expected benefits realisation affecting the organisation's financial position.	28/09/2018	(4) Will probably recur, but is not a persistent issue	(5) Catastrophic	20	(4) Will probably recur, but is not a persistent issue	(5) Catastrophic	20	EPR benefits lead for the programme is undertaking a detailed review of the realisable benefits to assess viability.	17 APR2018: Proposal agreed by Executive Management Team and work on benefits now to be initiated. 14 MAR 2018: Proposal under review. 7 FEB 2018: Proposal for alignment of work with improvement programmes completed and to be reviewed by Executive Management Team to initiate detailed work. 9 JAN 2018: Benefits work initiated including alignment of work, data, and planning 15 NOV 2017: Benefits realisation will now be planned. 11 OCT 2017: EPR went live 23 Sep 2017. 18 SEP 2017: No further update. To be updated three months post Go-Live. JUL 2017: Business case updated and submitted. MAY 2017: Benefit profiles and plans being updated for resubmission of FBC in July 2017. 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.	31/08/2018	High

[illegible]

[illegible]

2561	12/05/2015	Fedell, Cindy	Escalated from Integrated Risk Register Review Meeting	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.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Contract resources continue on site. Recruitment continuing.	16 APR 2018: HR change process to support the restructure activities is now underway. Formal apprenticeship programme actively being planned for intake. 14 MAR 2018: New Head of BI now in post. Restructure plans progressing. 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. 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. 6 DEC 2017: Review of structure and job roles underway as posts remain difficult to fill. Recruitment activities continue. 15 NOV 2017: Plans continue 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	28/09/2018	Moderate
3091	24/04/2017	Holden, John	Board of Directors Meeting	There is a risk that decisions of WYHP and/or WYAAT lead to enforced actions which the Board might consider are not in the best interests of the local patient population, or which could impact adversely on BTHT operations/finance/service viability and so hinder delivery of clinical strategy. WYHP: West Yorks & Harrogate Health & Care Partnership WYAAT: West Yorks Assoc of Acute Trusts	02/05/2018	(3) May recur occasionally	(4) Major	12	(3) May recur occasionally	(4) Major	12	BTHT contributed to the development of the original STP and has been actively represented on various governance groups (eg STP Leadership Forum, WYAAT Committee in Common) policy/professional groups (eg Medical Directors Group, Directors of Finance Group) and in the formulation and monitoring of programmes of work (eg Chair of West Yorks Cancer Alliance Board) etc.	March 2018: ICS Expression of Interest submitted 16 Feb after SLEG discussion in which BTHT Exec supported direction of travel but highlighted immaturity of processes and controls. BTHT ongoing involvement in drafting discussions re SLEG MOU, and in specific programmes eg to determine location of vascular arterial centre February 2018: WYHP has 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 ALB to enable WYHP to become an "Integrated Care System (ICS)". BTHT 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 eg erossed	30/04/2018	High
Principal risks: 50. To be assigned															
3142	07/02/2017	Shannon, Sandra	Risk Assessment	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. 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.	15/05/2018	(3) May recur occasionally	(5) Catastrophic	15	(3) May recur occasionally	(5) Catastrophic	15	None at present. E&F concerned that potential structural issues remain - to be discussed at CRAG 31.08.17 meeting.	17 April 18: A business case has now been presented to EMT which was approved subject to financial sign off. March 18 - Business case to be considered for off site storage February 2018: Business Case is will be presented to the next Business Case Review meeting. October 2017: Business Case to be produced The best and safest solution is to vacate the building, however space needs to be found to house the current notes •Baper produced & discussions held with Execs, scoping exercise to be carried out to determine what is required. •Baper 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. E&F concerned that potential structural issues remain - to be discussed at CRAG.	31/05/2018	Low
3223	15/03/2018	Claridge, Tanya	Escalated from Integrated Risk Register Review Meeting	There is a risk to the Trust's reputation and a risk that the Trust may be contravening the Human Tissue Act through non-compliance with Human Tissue Authority guidance.	31/05/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	The Trust has a Designated Individual as required under the Act. A Human Tissue Management Group is in place. A Consent policy is in place which refers to human tissue.	The Toft of the Human Tissue Group need reviewing The Trust needs to communicate with the Coroner as to the storage of tissue connected to Coronial PMs such that the Trust is meeting the legislation and guidelines Staff training needs to be in place and monitored in line with HTA standards There needs to be an annual audit to ensure compliance with the Human Tissue Act	31/07/2018	Low

3068	15/03/2017	Claridge, Tanya	Legal requirement	There is a financial, reputation and safety risk as the Trust is non-compliant with the Carriage of Dangerous Goods Regulations 2009.	31/05/2018	(3) May recur occasionally	(4) Major	12	(3) May recur occasionally	(4) Major	12	<p>All relevant departments within the Trust have been made aware of the serious breaches identified above.</p> <p>Corporate health and safety committee have been made aware of the November 2016 report and a task and finish group is to be set up.</p>	<p>March 2018: The Audit report was presented to the Health & safety Committee. There is an extensive action plan, which was approved, for the Trust to be fully compliant. Many of the actions are not due to be completed for 3 to 4 months.</p> <p>February 2018: Report and action plan to be discussed at H&S Committee in March 2018.</p> <p>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.</p> <p>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.</p> <p>A task and finish group is being set up to deliver an action plan to implement the appropriate remedial action.</p>	31/07/2018	Moderate
2841	24/03/2016	Shannon, Sandra	Legal requirement	Potential of prosecution due to poor segregation and contamination of waste across the organisation	15/05/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	18	(3) May recur occasionally	(4) Major	12	<p>All clinical waste in high risk areas consigned as 'yellow' waste</p> <p>Re-training of waste staff on correct consignment of waste</p> <p>Changes to waste disposal rooms at maternity and ENT to allow better segregation</p>	<p>17/04/18 Training attendance is lower than required. A new training approach is being developed; primarily non face to face methods.</p> <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> <p>Feb 2017:Audit undertaken. Action plan developed.</p>	30/04/2018	Moderate