

Board of Directors: 12.7.18
Agenda Item: Bo.7.18.7

Board Assurance Framework Quarter 1 2018/19

Presented by:	Tanya Claridge Director of Governance and Corporate Affairs	Author:	Tanya Claridge Director of Governance and Corporate Affairs
Previously considered by:	Board of Directors Executive Directors Board Committees		

Key points	Purpose:
1. This paper presents the Board Assurance Framework for Quarter 1 2018/19	To discuss and approve
2. The paper provides a summary of substantive changes to the Board Assurance Framework made including <ul style="list-style-type: none"> A proposed refresh of the Board Risk Appetite Statement developed following review at Board Committees A change in Key Performance Indicators for Strategic Objective 1 The addition of action plans to describe actions being taken to mitigate or remedy gaps in control or assurance 	To discuss and approve
3. The Corporate Risk Register is attached for review and contextualisation of the principal risks within the Board Assurance Framework	To discuss and note

Executive Summary:
<p>The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. Assurance can be secured through a range of sources, but wherever possible, it should be systematic, consistent, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its assurance committees, through audit and other sorts of independent review, and by the systematic collection and analysis of performance data, to demonstrate the achievement of its strategic objectives. The Board Assurance Framework is a live document that is populated and amended as risks and assurances associated with the organisational strategic objectives are identified.</p> <p>The Board of Directors receives the Board Assurance Framework (BAF) quarterly, prior to receipt at Board the BAF is reviewed and challenged through the relevant Board Committees and the Integrated Governance and Risk Committee.</p>

In November 2017 the Board of Directors received and approved the Trust's Risk Appetite Statement for 2017-20. That statement proposed that the Board reaffirms its risk appetite on an annual basis. This report proposes the Trust's 2018/19 Risk Appetite Statement. The risk appetite agreed by the Board should clearly govern the activities across the Trust. It also defines the boundaries within which the Trust's strategic objectives should be pursued. From an operational risk perspective this is fundamental as operational risk identification and assessment is undertaken in relation to the Trust's strategic objectives. Such clarity should facilitate informed decision-making throughout the organisation on operational risk-related topics.

Within the Board Assurance Framework a number of amendments have been made which require Board approval:

- 1) the key performance indicators for strategic objective 1 (to provide outstanding care for patients) have been reviewed and refreshed; the Board is asked to approve these amendments.
- 2) Action plans to mitigated or remedy gaps in control or assurance have been added to the template for each strategic objective

Also within appended to this report is the corporate risk register. The Board is asked to note this.

Financial implications:

No
Choose an item.
Choose an item.
Choose an item.
Choose an item.
Choose an item.

Regulatory relevance:

Monitor:	Risk Assessment Framework
	Quality Governance Framework
	Code of Governance
	Choose an item.

Equality Impact / Implications:	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
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) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what is the mitigation against this?	

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Other:	CQC Fundamental Standards of Quality and Safety
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Strategic Objective: <i>Reference to Strategic Objective(s) this paper relates to</i>	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

1. Board Assurance Framework

The Board Assurance Framework for Quarter 1 2018/19 is appended to this document (Appendix 1).

The key performance indicators for strategic objective 1, to provide outstanding care to patients have been amended by the lead Executive Directors. The indicators are now

- To achieve the NHS quality of care standards
- To continuously improve in all services over the cycle of the clinical services strategy and have no services rated as requires improvement or inadequate.

The Board of Directors is asked to consider and approve this change to the Board Assurance Framework.

Action plans to mitigate or remedy any gaps in controls or assurance have been added to the Board Assurance Framework by the Director of Governance and Corporate Affairs. These action plans are designed to provide the Board and Board Committees with assurance that timely and sustainable measures are being taken to address these identified gaps.

The Board of Directors is asked to consider and approve this change to the Board Assurance Framework.

2. Risk appetite statement

Effective strategic risk management is built around a clear understanding of how much risk an organisation is prepared to take to deliver its objectives, and a timely and reliable evaluation of how much risk it is actually taking.

The amount of risk Bradford Teaching Hospitals NHS Foundation Trust is prepared to accept or be exposed to (its risk appetite) will vary according to the perceived significance of particular risks, timing (it may be more open to risks at different points in time), and regulatory or legislative constraints. The Board may be prepared to take comparatively large risks in some areas and none at all in others.

This document defines and communicates the Trust's key operational risk appetite-related concepts and criteria, as identified within the operational risk appetite framework of the Trust. It also serves to provide clear guidance to all staff that the operational risk appetite agreed by the Board should clearly govern the activity across the Trust. It also defines the boundaries within which the Trust's strategic objectives should be pursued. From an operational risk perspective this is fundamental as operational risk identification and assessment is undertaken in relation to the Trust's strategic objectives. Such clarity should facilitate risk informed decision-making throughout the organisation on operational risk-related topics.

The Trust believes that the benefits of having a defined and well-communicated operational risk appetite in place include:

- Better allocation of resources
- Demonstrably improved / consistent decision making, and
- Effective alignment between strategic goals, and operational activities.

2.1 Purpose of the Trust's risk appetite statement

The Trust's risk appetite statement should be used as a key reference in the following circumstances:

- When an individual or group is making a significant business decision related to the business operations of the Trust. Examples of such decisions may include outsourcing significant processes or IT systems, introducing new technology within services, or changing the location of delivery of services. In such scenarios the statement should provide clear guidance on the Trust's approach regarding which operational risks are acceptable and which are unacceptable
- When an individual or groups are performing risk assessments and they need to identify whether the risk exposures are aligned with the organisation's approach regards acceptable and unacceptable operational risks
- When a new Board member or senior manager joins the Trust and needs to understand the Trust's approach towards which operational risks are acceptable and which are unacceptable
- When an external stakeholder (such as a regulator) wants to review the Trust's approach towards which operational risks are acceptable and those that are unacceptable.

2.2 The Trust's Risk appetite statement: July 2018

Through the Board Committees and the review of the corporate risk register a number of changes are proposed to the Board's risk appetite statement. The changes are presented in italics.

At a meeting of the Trust's Board of Directors on the 12 July 2018 the Trust's strategic objectives were used, alongside the principal risks managed by the organisation, as a framework to support the reaffirmation of the Trust's risk appetite.

The Board of Directors recognises that the Trust's long term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community, and our strategic partners is dependent upon the delivery of our strategic objectives. *It also recognises that the "Requires Improvement" rating applied to the Trust by the CQC in 2018 also has a strong influence on the risk appetite of the organisation.*

The Trust has preference for ultra-safe delivery options that have a low degree of inherent risk, as little as reasonably possible and/or materially affect patient safety, patient experience, or clinical outcomes. The Trust also has a minimal risk appetite in relation to regulatory compliance. It will ensure that it is compliant with the standards and conditions that our regulators impose unless there is strong evidence to challenge what is required.

The Trust will adopt a cautious approach to financial risk. It is prepared to invest for potential return and is prepared to invest in resources that deliver improvements in quality and patient safety. It is clear that any financial decisions impacting on the services the Trust provides must be subject to rigorous quality impact assessments. The Trust also has a cautious approach to commitments other than those related to

the quality of care that it provides. This cautious view of financial risk is reflected in our view of commercial risk. The Trust will support low risk opportunities in established business areas or in areas where it wishes to secure continuity to the services which it believes benefits its patients or has a significant contribution to the delivery of its strategic objectives.

The Trust has a cautious appetite in relation to risks associated with the delivery of operational performance targets. It has a preference for safe, 'tried and tested' delivery options which have a low degree of inherent risk recognising that they may only have a limited potential for reward.

The Trust will also not accept risk where it involves potential exposure to significant harm for employees. Examples include:

- Bullying or harassment of employees by their managers or colleagues
- Discrimination of employees by their managers or colleagues
- Exposing employees to faulty machines or equipment
- Exposing employees to machines or equipment where this may result in a detrimental known impact on the health of the employee.

However in relation to other elements of achieving the strategic objective to be in the top 20% of employers in the NHS, the Trust whilst having a preference for safe delivery options that have a low degree of inherent risk to patient safety and may only have limited potential for reward, is beginning to be willing to consider all potential delivery options and choose these, while also providing an acceptable level of reward.

The Trust recognises that to be a continually learning organisation it must have at least an open approach to the risks associated with innovative practice, particularly in relation to education, training, and the use of new technology to support learning.

The Trust has a seeking approach to collaboration with its local and regional partners. The Trust is eager to be innovative and to identify options that will potentially deliver higher business rewards. It understands that this seeking approach may lead to increased scrutiny of and interest in the organisation as new and innovative system-wide ways of working with our partners are explored and defined.

The Board of Directors is asked to consider and approve this change to the Board Assurance Framework.

Implementing risk appetite through risk tolerance

All risks

- Where the residual risk, following the implementation of controls, is rated medium or above this will be managed and monitored on the Trust's risk register
- Where the residual risk relating to patient or staff safety or regulatory compliance (that is, following the implementation of controls) is higher than the target risk this will be managed on the Trust's risk register
- Where the residual risk, following the implementation of controls, is rated high or above this will be monitored corporately
- Where the residual risk score is more than eight lower than the initial risk score this will be subject to additional assurance reviews of the effectiveness of the controls in place.

Implementing risk appetite through Trust-Wide controls

The risk appetite of the Trust should be implemented through existing Trust-wide controls.

Policy

The Trust's risk appetite should be reflected in new policies or revised clauses within existing policies, where appropriate. For instance:

- Clauses within the Health & Safety Policy relating to the safety of employees
- Clauses in the Incident Management Policy relating to learning.

Governance

The Trust's risk appetite should be embedded in its corporate governance structures, its Board, Committees, and the associated risk escalation framework. The described risk appetite should be a visible part of the Board Assurance Framework to ensure those with accountability for the delivery of the Trust's strategic objectives are able to appropriately contextualise the information and assurance provided to them.

Training and education

The strategic approach to training and education should be underpinned by the risk appetite of the organisation, for instance its focus on mandatory training, staff development, embedding learning from precursor events into training, and developing and supporting innovative approaches to learning.

Internal audit and ProgRESS

The annual internal audit programme and the Trust's own internal assurance programme should be directly influenced by the Trust's risk appetite with a clear focus on assurance in areas where the Trust's appetite for risk is minimal and where there are risks where the mitigation required is significant.

Customised risk appetite statements for Clinical Divisions and Corporate Directorates

This risk appetite statement has been defined to be applicable for both the clinical division and corporate directorate levels within the organisation and hence any context specific to these levels has not been included. It is expected that clinical divisions and corporate directorates will utilise this document as a basis for creating a risk appetite statement document for their risk owners and other stakeholders. Such customised statements should include contextual information specific for the clinical division or corporate directorate so its content can be relevant for the users of the statement. Such customisation should retain the criteria defined within this document. New criteria can be added but existing criteria cannot be modified or removed. The Integrated Governance and Risk Committee should approve any clinical division- or corporate directorate-specific version of risk appetite statements. If a clinical division or corporate directorate does not define a customised version of the risk appetite statement then this document will be applicable for all its risk appetite related activities (including for reporting).

Review of risk appetite statement

The Trust's risk appetite statement will be reviewed retrospectively and prospectively at least annually and an annual risk appetite statement approved by the Board of Directors.

3. Corporate Risk Register

The Corporate Risk Register is attached at Appendix 2 of this document

BOARD ASSURANCE FRAMEWORK: Quarter 1 2018/19

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. Assurance can be secured through a range of sources, but wherever possible, it should be systematic, consistent, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its assurance committees, through audit and other sorts of independent review, and by the systematic collection and analysis of performance data, to demonstrate the achievement of its strategic objectives. The Board Assurance Framework is a live document that will continue to be populated and amended as risks and assurances associated with the organisational objectives are identified

BOARD ASSURANCE FRAMEWORK											Q1 2018_19
Assurance Overview						Date		5 th July 2018			
Strategic Objective		Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk	
						2017/18		2018/19			
						Q3	Q4	Q1	Q2	Principal composite	Highest
1	To provide outstanding care for our patients	Confidence	The Quality Committee regularly receives a range of reports covering all domains of quality. The reports received are based on the annual work plan. The Committee also receives reports and presentations relating to specific areas of risk or interest. These are determined though the analysis of risk. There is confidence that there are structures and processes in place to support mitigation of risk associated with the achievement of this strategic objective, these structures and processes are available and being used by the organisation.	Chief Nurse/ Medical Director	Quality					12	16
2a	To deliver our financial plan	Limited confidence	Limited confidence: the financial plan was being delivered in month 1, however this is against a low CIP requirement in quarter 1. The requirement to deliver the annual CIP of £25m steps up in subsequent quarters and represents a material change in the underlying monthly run rates.	Director of Finance	Finance and Performance					16	16
2b	To deliver our key performance targets	Limited confidence	Limited Confidence: Current performance against trajectories indicate that there is limited confidence in delivering the required standard in quarter: Recovery plans are in place for the contractual KPIs for RTT, ECS and Cancer. These are yet to deliver.	Chief Operating Officer	Finance and Performance					16	20
3	To be in the top 20% of employers in the NHS	Limited confidence	Limited Confidence: Evidence presented to Committee shows significant progress and assurance in a number of areas. Concerns re vacancies in key areas remain with performance below KPI in some areas	Director of Human Resources	Workforce					12	12
4	To be a continually learning organisation	Confidence	Confidence: evidence presented to committees demonstrates the significant progress made, recognising that there are further opportunities for change and improvement	Medical Director	Quality						
5	To collaborate effectively with local and regional partners	Confidence	Confident: Partnership work for all acute collaboration and vertical integration is necessarily dependent on the work and cooperation of external organisations, which means elements of partnership work will always be beyond the direct influence and control of BTHFT, but within that context we believe our mitigations are effective. Partnerships Committee, 25 May (P.5.18.9)	Director of Strategy	Partnerships					12	12

BOARD ASSURANCE FRAMEWORK		Strategic Objective		1		To provide outstanding care for our patients				Assurance Level		2017/18		2018/19	
												Q3	Q4	Q1	Q2
Executive Lead		Karen Dawber/Bryan Gill				Assuring Committee		Quality							
Positive Assurance			Negative Assurance			Gaps in Assurance			Rationale for Assurance Level						
Date	Assurance	Source	Date	Assurance	Source										
Monthly	Serious Incident report Safe Staffing Quality Committee Dashboard and trend analysis Information Governance report Quality oversight system	Report to Quality Committee	Monthly	Safe Staffing report Quality Committee Dashboard and trend analysis	Report to Quality Committee										
Quarterly	Risk Management Leadership walk around programme Clinical Effectiveness ProGRESS Learning from deaths Learning	Report to Quality Committee	Quarterly	Clinical Effectiveness report Annual Clinical Audit report	Report to Quality Committee										
Annual	FTSU annual report (incl Q4) Patient experience report (incl Q4) Safeguarding annual report (s) High priority audit plan Annual Clinical Audit report Quality Account Annual Security Report Annual Infection Control (incl Q4) Maternity Annual report	Report to Quality Committee	Annual	Patient Experience annual report (FFT response, overdue complaints)	Report to Quality Committee										
May June May June	Maternity Improvement Plan Stroke Improvement Plan Focus on pressure ulcers Focus on falls	Report to Quality Committee	May May June In quarter June	Sepsis Audit Paediatric diabetes national audit SSNAP data in stroke improvement plan Never Events (x3) Care Quality Commission Report	Report to Quality Committee										
Key performance Indicator		Principal Risk (s)		Potential consequences		Composite risk rating					Component risks				
						Initial	Residual	Target	Current	Direction of travel	Number	Highest Current			
a	To achieve the NHS quality of care standards	1	Failure to maintain the quality of patient services	Poor quality of care to the population that we provide services for. Reduced reputation and risk to continuity of services		16	8	4	12	↔	21	16			
b	To continuously improve in all services over the cycle of the clinical services strategy and have no services rated as requires improvement or inadequate.														
High Level Controls		Gaps in controls		Routine Sources of Assurance					Risk Appetite						
Clinical Service Strategy 2017-22 Various frameworks that underpin clinical strategy. Quality dashboard Sub-Committees of the Quality Committee National Audit Programme Quality Oversight System Quality Improvement Strategy Structured Judgement Review Process Policy and procedure related to the management of precursor incidents (e.g. incidents/claims/complaints) Risk management strategy CQC steering group		Lack of real time reporting of quality information Sepsis indicators		Ward to board reporting and the committee structures Patient experience report Risk management report Effectiveness Report CQC compliance reporting Safeguarding report Learning report Friends and Family Test Patient Survey Dashboards Quality Committee Dashboard Board Integrated Dashboard					Minimal. (as little as reasonably possible) preference for ultra- safe delivery options that have a low degree of inherent risk						

CQC compliance action plan Workforce Committee		National reports:	
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients	Action Plan to address Gaps in Controls and Assurance
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				Date of update	June 2018
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Chief Nurse (CN)	Quality Committee		Deputy Medical Director (DMD)	Infection Prevention and Control Committee Patients First Committee Information Governance Committee	
Medical Director (MD)			Deputy Chief Nurse (DCN)		
			Nurse Consultant IPCC (NCIPCC)		
			Head of Business Intelligence (HBI)		

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To develop functionality to enable real time quality metric reporting	HBI	June 2018	TBC	O		This is part of ongoing work to optimise the data available from EPR and its associated analytics		
2	To ensure that the Trust has appropriate metrics and processes in place to monitor the quality of sepsis care and management	CNIP CC	June 2018	October 2018	O				

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To ensure that the national inpatient survey and a summary of recommendations is received by the Quality Committee in July 2018	KD	June 2018	July 2018	O				

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2a	To deliver our financial plan	Assurance Level	2017/18		2018/19	
						Q3	Q4	Q1	Q2
Executive Lead	Matthew Horner			Assuring Committee	Finance and Performance				

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
June 18	Financial Plan submitted	Bradford Improvement Plan to F&P Committee & Board of Directors	June 18	Financial Plan broadly on line at end of month 1 albeit with contract income under trades and CIP shortfalls being offset by fortuitous run rate underspends	Month 1 F&P Finance Report	Definitive plans in place to secure full value of CIP requirement	Limited confidence: the financial plan is currently being delivered in month 1, however this is against a low CIP requirement in quarter 1. The requirement to deliver the annual CIP of £25m steps up in subsequently quarters and represents a material change in the underlying monthly run rates.
June 18	Expenditure Budget Re set (realigned to reflect 17/18 run rates)	Budget Setting Paper to F&P Committee	June 18				
June 18	Introduction of key enablers to facilitate tracking and delivery of financial plan (eg weekly activity trackers)	Weekly activity trackers presented to F&P committee (May 18)	June 18	Activity and Income under trade reported for month. Activity allocation to Specialty and Point of Delivery not available for month 1 to undertake deep dive/analysis – detailed plan to be submitted to June F&P Committee	Month 1 F&P Finance Report	Complete alignment of contract activity and income plan to capacity availability quantified from demand and capacity project	
June 18	Bradford Improvement Programme (BIP) governance & performance management arrangements	Presented to F&P Committee and Board of Directors	June 18	Limited expectation in Q1 for CIP delivery but embedding of BIP processes and structures limited in months 1 & 2	Month 1 F&P Finance Report	Definitive plans in place to secure full value of CIP requirement	

Key performance Indicator		Principal Risk(s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	Deliver a NHS Improvement Use of Resources rating of at least “2”	4	Failure to maintain financial stability	Damage to reputation, financial compromise, loss of market share, regulatory action	16	10	10	16	↑	5	16

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
<p>Executive led Divisional Financial performance management meetings</p> <p>Bradford Improvement Plan Governance process and performance management of CIP delivery</p> <p>Budget setting and business planning</p> <p>Quality Impact Assessment and Financial Impact Assessment process – Improvement plan</p> <p>Chief Executive CIP confirm and challenge meetings with COO & FD</p> <p>Standing Financial Instructions and Scheme of Delegation</p>	<p>As at Month 1 – BIP management and governance processes not embedded across the organisation</p> <p>Detailed specialty and point of delivery activity and income plans not available to compare to month 1 actuals</p>	<p>Director of Finance report to Finance and Performance Committee and Board – including assessment of NHSI ‘Use of Resources’ framework</p> <p>Bradford Improvement Plan Report to Finance and Performance Committee and Board of Directors</p> <p>Internal Audit Committee Reports on controls assurance</p> <p>Audit Committee Report to Board</p> <p>Finance & Performance Committee Dashboard</p> <p>Board Integrated Dashboard</p>	<p>Cautious</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To achieve our financial plan	Action Plan to address Gaps in Controls and Assurance
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				Date of update	June 2018
Accountability				Responsibility	
Lead	Oversight/governance structure			Lead	Work-stream/operational group
Director of Finance (DoF)	Finance and Performance Committee				
Chief Operating Officer (COO)					

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	As at Month 1 – BIP management and governance processes not embedded across the organisation	DoF COO	31.5.18	30.6.18	OC		BIP Documentation to be completed for all known schemes by end of May – Meeting Structure, Monitoring & Performance Management arrangements to be embedded throughout June	BIP documentation developing and being presented to BIP Programme Board	
2	Detailed specialty and point of delivery activity and income plans not available to compare to month 1 actuals	COO	30.5.18	28.6.18	OC		Detailed activity plans at specialty and point of delivery level to be created and shared with Divisions. Consolidated position with principles & rationale to be reported to EMT and F&P Committee in June 2018	Action/Recovery plan under development with operations, informatics and contracting contributing	

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	Full value of CIP to be identified and ratified/approved via BIP governance process	DoF	1.4.18	30.6.18	OC		BTHFT submitted plausible plan to deliver control total but faces a significant CIP challenge. The Trust does not have access to the non recurrent measures deployed over recent years and is reliant on recurrent/sustainable improvement to deliver the challenge.	The finance report to Finance & Performance Committee identifies the current status of the CIP programme and the underlying gap	
2	Alignment of contract activity and income plan to capacity availability quantified from demand and capacity project	DoF	1.5.18	31.7.18	OC		The challenge to agree a contract income quantum that directly aligns to the internal available capacity (given the data quality issues in the latter half of 2017/18) has resulted in a mismatch. A reconciliation is underway to identify and quantify the implications of any potential mismatch	Given the data quality improvement work underway, the ability to provide an accurate reconciliation is challenged	

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2b	To deliver our key performance targets			Assurance Level	2017/18		2018/19	
								Q3	Q4	Q1	Q2
Executive Lead	Sandra Shannon			Assuring Committee		Finance and Performance					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
May 18	Implementation of the action plan to improve the ECS performance	ECS Action Plan	May 18	Current performance in relation to ECS standard	Performance Report to Finance & Performance Committee	Delays in validating 4 hour breach position	<p>Limited confidence: current trajectories indicate that there is limited confidence in delivering the required standard in quarter. Although there has been a small increase in performance against standard there is still significant variation in performance on a day to day basis.</p> <p>The 62 day backlog is still increasing at the same rate as patients are being removed. There are also 2ww demand and capacity gaps for dermatology and LGI. Both of these indicate limited confidence that cancer standard will be achieved in quarter.</p> <p>There are a number of specialties showing a significant demand and capacity gap. Many have waiting lists that are over-sized and unless there is a reduction in waiting list sizes the trust will be unlikely to be able to achieve 18 weeks RTT.</p>
	Daily performance reporting of ECS	EPR – Trust performance team		ECS- there is an over reliance on flexible staffing to provide adequate staffing levels to meet the needs of emergency demand	Staffing rotas.	There is a mismatch in 2ww 1 st OPD capacity to demand in dermatology which will significantly impact on overall 2ww performance	
May 18	Implementation of the action plan to improve the Cancer 62 Day performance	Cancer 62 day performance Action Plan	May 18	Current performance in relation Cancer 62 day standard	Performance Report to Finance & Performance Committee	Data quality issues in 18 week PTL and lack of staff resources to undertake full validation.	
	Cancer waiting time dashboard	PPM – Cancer Manager		No reduction in 62 day backlog	Cancer dashboard	DQ issues may provide an inaccurate position against 18 week RTT standard.	
May 18	Implementation of the plan to reduce elective waiting times	ECR action plan	May 18	Current performance in relation to RTT 18 week access standard	Performance Report to Finance & Performance Committee		
	Weekly 18 week RTT performance against trajectories	Incomplete PTL		Increase in over 18 week patients on waiting list	Access highlight report		
	Demand and capacity modelling	Outputs of D&C modelling		Reduction in elective activity against activity plan	18 week incomplete waiting list		

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
	To achieve organisational trajectories set for RTT, Cancer and ECS	3	Failure to maintain operational performance	Damage to reputation, financial compromise, loss of market share, regulatory action	20	6	6	16	↑	10	20
		6	Failure to maintain sustainable contracts with commissioners	Loss of market share, loss of public confidence, lack of service sustainability	12	6	6	15	↔	6	16

High Level Controls
<p>Executive led Divisional performance management meetings (national/local and contractual KPI's/standards)</p> <p>ECS performance action Plan</p> <p>Cancer 62 day action plan</p> <p>18 week RTT action plan</p> <p>Weekly Access Meetings</p> <p>2 weekly ECS breach review meetings</p> <p>Urgent Care Programme board</p> <p>Trust Improvement Committee work programmes – Urgent Care and Cancer</p> <p>Additional management support in place.</p>

Gaps in controls
<p>ECS- the current staffing model is not sufficient to meet current emergency demand</p> <p>Cancer – due to vacancies there is insufficient tracking of patients on the cancer PTL.</p> <p>Cancer – due to vacancies there is a delay in booking patients for 2ww appointment</p> <p>ECR – due to the increase in WL size there are insufficient validation staff available to undertake the required amount of validation which will impact on performance</p>

Routine Sources of Assurance
<p>Daily return to NHSI for ECS</p> <p>National cancer submission of cancer waiting times by standard</p> <p>Monthly national reporting of 18 weeks RTT through Unify</p> <p>Director of Finance - Performance report to Finance and Performance Committee and Board</p> <p>Audit Committee Report to the Board</p> <p>Contract Management Board</p> <p>Internal Audit Committee Reports on controls assurance</p> <p>Audit</p> <p>Finance & Performance Committee Dashboard</p> <p>Board Integrated Dashboard</p>

Risk Appetite
<p>Cautious</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance
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			Date of update	4/5/18
Accountability			Responsibility	
Lead	Oversight/governance structure	Lead	Work-stream/operational group	
DCD Medicine	Urgent Care Improvement Programme	AED leadership	Emergency care Access and flow	
DCD Medicine	Urgent Care Improvement Programme	Service Manager Patient flow	Hospital Flow and discharge	
Deputy COO	Cancer Improvement Programme	Cancer Service manager	Cancer delivery group	
Head of Planned Access	Elective Care recovery Programme	Deputy COO	Elective access delivery group	

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	ECS- To implement a substantive staffing model that matches staff resource with emergency demand	COO	May 18	31/5/18	O		A draft business case is in development – to be tabled at EMT 22/5/18	
2	Cancer- To implement a team restructure that provides a more integrated MDT	CSM	May 18	31/9/18	O		The formal consultation process has commenced to combine MDT co-ordinators and pathway trackers into tumour site specific teams which will provide greater oversight and operational grip of pathways management.	
3	Cancer- To temporarily increase the number of staff within the 2ww booking team	CSM	May 18	31/5/18	O		Additional temporary staff will be employed to cover vacancies and clear 2ww backlog	
4	ECR- To implement a data quality recovery plan and reduce waiting list errors at source	C S	May 18	31/12/18	O		Plan in place and progressing – impact monitored through Cymbio DQ dashboard	

Objective	2	To address gaps in assurance related to achievement of this strategic objective						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	To put in place a process for early morning validation of all 4 hour breaches to ensure accurate reporting by 11 am.	AED CL	May 18	31/5/18	O			Validation SOP
2.	Cancer – To put in place a detailed recovery plan for dermatology 2ww and identify options for creating additional 2ww 1 st OP capacity	COO	May 18	30/6/18	O		A detailed recovery plan has been put in place following a dermatology summit with options identified for creating 2ww capacity	Dermatology 2 WW recovery plan Action plan following dermatology summit
4	ECR- To increase the central access team staffing and undertake a programme of detailed validation of the waiting list.	HPA	May 18	31/12/18	O		Approval has been given for additional staff to undertaken validation. A programme of validation is in development. It is expected that a total waiting list validation will take place over the next 6 months.	

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK		Strategic Objective	3	To be in the top 20% of employers in the NHS			Assurance Level				
								Q3	Q4	Q1	Q2
Executive Lead	Pat Campbell			Assuring Committee		Workforce					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	Routine access to comparator data in some areas	Evidence presented to Committee shows significant progress and assurance in a number of areas. Concerns re vacancies in key areas remain with performance below metric in some key areas. Q1 assigned assurance level to be confirmed at July Workforce Committee.
April/May 2018	Workforce report Nurse staffing data publication report People Strategy annual plans NHS Staff Survey results , improvement in staff engagement scores and staff survey action plan Quarterly guardian of safe working hours report FTSU annual report Apprenticeship Levy report	Workforce Committee	March 2018	Staff engagement/experience scores for disabled staff	NHS Staff Survey		
March 2018	Engaged workforce – high assurance Staffing Utilisation , junior doctors – significant assurance	Audit Yorkshire	April/May 2018	Workforce report re appraisal rates, vacancy position particularly in nursing, theatres FTSU report re harassment and bullying Nurse staffing data publication report Guardian of Safe Working Hours report SFFT results Q4 due to response rate	Workforce Committee		
May 2018		Audit Yorkshire					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
A	Achieve a Friends and Family Test (Staff) result showing a target percentage of staff recommending the Trust as a place to work	2	Failure to recruit and retain an effective and engaged workforce to meet the needs of our Clinical Services Strategy	Disengaged staff – poor staff morale High staff turnover High vacancy rate/agency staff usage Poor quality and continuity of care Unanticipated bed closures	15	6	4	12	↔	3	12
B	To be in the top 20% of places to work as measured by the NHS staff survey though a year on year improvement in staff engagement scores										
C	To deliver good performance on recruitment fill rates and turnover as benchmarked against other acute hospitals										
D	To employ a workforce representative of our local communities in line with our Equalities Objectives/WRES action plan										

High Level Controls
Divisional performance management Workforce dashboard Monitoring of safe staffing Monitoring of recruitment against budget Time to talk Our People Strategy 2017 and workplans Personal responsibility framework Guardian of Safe Working Hours reports Workforce planning Staff survey action plan Annual review of nurse and midwife staffing establishments Mandatory training and appraisal performance management Education and workforce Committee Human Resources Policies and Procedures Equality objectives/ WRES Action plan NHS QUEST Standards when developed

Gaps in controls
Contemporaneous staff experience data Urgent Care staffing model – does not meet demand – refer to action plan under 2b Workforce plan to match clinical services strategy

Routine Sources of Assurance
Workforce report Workforce Committee Dashboard Board Integrated Dashboard HEE workforce return Junior Doctor fill rates Update report on staff survey action plan Nurse recruitment and retention plan GMC survey Nurse staffing data publication report Bi-annual review report of nurse and midwife staffing Medical appraisal and revalidation report Quarterly ‘freedom to speak up guardian’ return Workforce Race Equality Standard Report Guardian of safe working hours report Staff Friends and Family Test EWin/Model Hospital portal for benchmarking purposes Audit reports Leadership walkarounds

Risk Appetite
Cautious/open – Preference for safe delivery options that have a low degree of inherent risk to patient safety and may only have limited potential for reward, but beginning to be willing to consider all potential delivery options and choose while also providing an acceptable level of reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of Employers in the NHS	Action Plan to address Gaps in Controls and Assurance
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				Date of update	
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Director of Human Resources (DHR)	Workforce Committee		DHR	Education and Workforce Sub Committee	
			Deputy Director of Human Resources (DDHR)		
			Assistant Director of Human Resources (ADHR)		

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To review methods for getting more contemporaneous staff experience data out with SF&F and NHS Staff Survey	DDHR	01.07.2018	30.09.2018	0		To be picked up through staff engagement actions and reported to E&W Committee	Proposal developed	
2	To undertake a strategic workforce review	DDHR	06.2018	31.03.2019	0		Terms of reference being developed and consultancy support to be determined.		

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	nil								

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK		Strategic Objective	4	To be a continually learning organisation			Assurance Level	2017/18		2018/19		
								Q3	Q4	Q1	Q2	
Executive Lead		Bryan Gill			Assuring Committee			Quality Committee				

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	<p>Agreed Key Performance indicators and access to comparator data</p> <p>Publication and embedding of a Trust-wide strategy on continuous learning</p> <p>Identification of risks associated with the delivery of the objectives.</p>	<p>Confidence: evidence presented to committees demonstrates the significant progress made, recognising that there are further opportunities for change and improvement</p>
April 2018	Serious Incident Report	Quality Committee					
	Risk Management report	Quality Committee					
	Leadership Walk round update	Quality Committee					
May 2018	ProgRESS report	Quality Committee					
	Learning from Deaths report	Quality Committee					
	Serious Incident Report	Quality Committee					
June 2018	Serious Incident Report	Quality Committee					
	Combined Learning Report	Quality Committee					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
1	To achieve 5% year on year training of clinical staff in Quality Improvement	8	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	Reputation, loss of HEE contracts, research funding, harm to patients, reduced recruitment and retention of staff	12	8	6	12	↔		
2	To deliver upper quartile performance for recruitment to time and target for NIHR portfolio studies										
3	Achieving upper quartile performance on national education surveys										
4	Continuous learning: Ratio of near miss to SI reporting [Learning culture]										

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
Research Committee Organisational learning system Trust’s Improvement Programme Quality oversight system National Audit Programme (Improvement) Patient safety/Clinical Effectiveness/workforce and education Sub-Committee NHS QUEST AHSN Improvement Academy BIHR Centre for applied health research HEE HEI		Quarterly learning report National Education Surveys ESR reports Board Integrated Dashboard National Audits	<p>Open: There is a willingness to support staff to innovate in methods of delivering continuous learning and improvement</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Action Plan to address Gaps in Controls and Assurance
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				Date of update	June 2018
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Dr Bryan Gill	Quality Committee & Patient Safety Sub Committee				

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	nil								

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	nil								

Status:	
O	Open
o	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK				Strategic Objective		5	To collaborate effectively with local and regional partners					Assurance Level		2017/18		2018/19		
Executive Lead		John Holden				Assuring Committee		Partnership Committee			Q3			Q4	Q1	Q2		
Positive Assurance				Negative Assurance				Gaps in Assurance				Rationale for Assurance Level						
Date	Assurance		Source		Date	Assurance		Source		We do not have an approved new risk on CRR assessing risk associated with a lack of understanding within the Trust of the depth/level of current collaboration work with AFT.				Confident: Partnership work for all acute collaboration and vertical integration is necessarily dependent on the work and cooperation of external organisations, which means elements of partnership work will always be beyond the direct influence and control of BTHFT, but within that context we believe our mitigations are effective. Partnerships Committee, 25 May (P.5.18.9)				
25 May	Partnerships Committee noted progress across “vertical” integration, “horizontal” integration and Acute service collaboration with Airedale NHS FT. Also approved updated work plan for 2018/19.		P.5.18.5 P.5.18.6 P.5.18.7 P.5.18.11		25 May	Partnerships Committee noted the difficulties of vertical integration work programmes, scope of the collab with AFT, and risks associated with moving to new ICS governance.		P.5.18.5 P.5.18.6 P.5.18.7										
Key performance Indicator		Principal Risk (s)			Potential consequences			Composite risk rating					Component risks					
								Initial	Residual	Target	Current	Direction of travel	Number	Highest Current				
1	Local integrated care (“vertical” integration): initially - assessment of inputs (progress in establishing governance groups, MOUs etc.); moving to - balanced scorecard of outputs/outcomes attributable to this work		7	Failure to deliver strategic partnerships		Missed opportunity to implement clinical strategy and improve patient care due to e.g. destabilised clinical services, loss of market share, reputational damage, financial loss, operational issues			12	9	9	12	↔	4	12			
2	System-wide planning & decisions (“horizontal” integration): initially - attaining milestones in establishing collab arrangements w/ Airedale FT; moving to - weighted assessment of progress across different services. Potential to consider WYAAT/STP measures for broader collaboration.																	
3	Acute service collaboration with Airedale NHS FT: we have some draft metric proposals for discussion at Partnerships Committee																	
High Level Controls			Gaps in controls			Routine Sources of Assurance					Risk Appetite							
1. Partnerships Committee meetings 2. EMT discussions (including time-out sessions) 3. Implementation of Clinical Services Strategy 2017-2022 through Divisional service planning and EMT updates 4. Participation in :- <ul style="list-style-type: none">STP System Leadership Exec GroupBradford & Districts Health & Wellbeing BoardBradford districts & Craven Integration & Change Board (ICB)Bradford Health & Care Partnerships Board (programme board for accountable care)Integrated Management Board (IMB) of Bradford Provider AllianceWYAAT Committee in Common			Need to better co-ordinate activity related to vertical integration, track progress and manage risks across BTHFT. “Head of Partnerships” appointed at interview 6 June; await start date			1. Stakeholder engagement survey 2. Pathology JV Board of Directors meetings (receives regular reports from Managing Director and Clinical Director) 3. WYAAT Programme Director’s Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops) 4. Papers for STP System Leadership Executive 5. Discussions and papers for Acute Collaboration Programme (with AFT) 6. Board Integrated Dashboard					Seek: Eager to be innovative and to choose options offering potentially higher business rewards							

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Action Plan to address Gaps in Controls and Assurance
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			Date of update	14 June 2018
Accountability			Responsibility	
Lead	Oversight/governance structure		Lead	Work-stream/operational group
Director of Strategy and Integration	Partnerships Committee of BTHFT Board		Head of Policy	Horizontal integration (WYAAT/STP); acute collaboration programme (ie AFT)
			Head of Partnerships	Vertical integration (Bradford); stakeholder engagement

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
2	Create a risk regarding lack of understanding of our current level/depth of collaboration with AFT	JH	20 June 2018	20 July 2018			Following issue being raised at 20 June IRGC, Head of Policy has drafted risk on Datix (3260) awaiting approval at IRGC on 20 July	Datix reference 3260; 20 June IRGC minutes	
1	Work with Governance Team to co-develop a risk for CRR in relation to proposals for future acute collab with Airedale FT	JH	1 March 2018	20 June 2018		20 June 2018	Head of Policy drafted risk which is on Datix and is scheduled for IGRC approval as required	Datix reference 3255; IGRC I.6.18.5	

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	Appoint dedicated "Head of Partnerships" to oversee and co-ordinate vertical integration	JH	1 Feb 2018	6 June 2018			Appointee has accepted job offer; appointment subject to usual checks, start date to be confirmed	Advert on NHS Jobs; HR paperwork	

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

Appendix 1 Corporate Risk Register

CORPORATE RISK REGISTER: PRINCIPAL RISKS

June 2018

	Principal Risk	Proposed Overall Risk Rating					Risk Appetite	
		Initial	Residual	Target	Current	Direction	Current	Profile
1	Failure to maintain the quality of patient services	16	8	4	12	↔	Minimal	
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	12	↑	Cautious/open	
3	Failure to maintain operational performance	20	6	6	16	↑	Cautious	
4	Failure to maintain financial sustainability	16	10	10	16	↑	Cautious	
5	Failure to deliver the required transformation of services	12	8	8	8	↔	Open	
6	Failure to achieve sustainable contracts with commissioners	12	6	6	15	↔	Cautious	
7	Failure to deliver the benefits of strategic partnerships	12	9	9	12	↔	Seek	
8	Failure to continually learn and improve the quality of care for our patients	12	8	6	12	new	Open	

Appendix 2: Board Assurance Framework Legend						
Descriptors		Defining risk appetite				
Principal Risk	What could prevent the Strategic Objective from being achieved?	0	Avoid	Avoidance of risk is a key organisational objective		
High Level Controls	What controls/systems do we have in place to assist secure delivery of the objectives?	1	Minimal	(as little as reasonable possible) preference for ultra- safe delivery options that have a low degree of inherent risk		
Gaps in Controls	Are there any gaps in the effectiveness of controls or systems?	2	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward		
Sources of assurance	Where can we gain evidence in relation to the effectiveness of the controls/systems which we are relying on?					
Positive Assurance	What evidence have we of progress towards or achievement of our strategic objective?	3	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward		
Negative Assurance	What evidence have we of progress towards our strategic objectives being compromised?	4	Seek	Eager to be innovative and to choose options offering potentially higher business rewards		
Gaps in Assurance	Where can we improve the evidence about the effectiveness of one or more of the key controls/systems which we are relying on?	5	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust		
Rationale for assurance level	(see Appendix 2) a description of the reason for the decision in relation to assurance level agreed by the assuring committee					
Risk Appetite	The level of risk the organisation is prepared to tolerate in relation to the secure delivery of each individual strategic objective					
Levels of assurance						
little or no confidence	Low. No evidence of necessary structure/processes supporting mitigation of risk associated with the achievement of strategic objective			Risk		
limited confidence	Compromised. Limited evidence of necessary structure/processes mitigation of risk associated with the achievement of strategic objective			Risk		
confidence	Confident. Range of structures and processes in place supporting mitigation of risk associated with the achievement of strategic objective available and used by the organisation			Opportunities for change and improvement		
High Confidence	Trust. Comprehensive evidence of effective and sustainable mitigation of risk associated with achievement of the strategic objectives			Opportunities for learning		

ID	Date of entry	Risk Lead	Source of risk	Description	Next review date	Likelihood (initial)	Consequence (initial)	Risk Level (initial)	Rating (initial)	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Existing control measures	Summary of risk treatment plan/mitigation	RISK: Target date	Risk Level (Residual)	Rating (Residual)
Principal risk: 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 IGMC 15.1.18 agreed to be added to CRH.	16/07/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	15	(3) May recur occasionally	(4) Major	High	12	Comply with national reporting requirements externally. Reporting in place through Divisional Performance Review and Finance & Directors. Weekly tracking process at patient level. 62 day breach review panel to undertake clinical harm review.	6/6/18 ZNW and 62 day recovery plans in progress. Full validation of endoscopy waiting list has taken place. Additional capacity being put in place to clear ZNW backlogs. Individual review of all patients over 62 days undertaken weekly and management plan agreed. 5/18 62 day breach review panel in place undertaking an assessment of clinical harm. Cancer board in place. 14/5/18 escalation meeting took place for dermatology and a number of actions for improvement agreed. Additional capacity being created for endoscopy ZNW clinics. 28/4/18 The cancer improvement plan continues to be implemented. Specialty specific action plans have 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 IGMC 15.1.18 agreed to be added to CRH.	30/04/2018	Moderate	4
3057	27/02/2017	Dawber, Karen	Escalated from Governance Committee	There is a risk that The Trust is not responding to complaints in a timely manner and ensuring that there is evidence of recommendations being implemented within the Datix system. The impact is poor patient experience and reputation.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	(5) Will undoubtedly recur, possibly frequently	(2) Minor	High	10	March 18 - New patient experience manager starts March 18, number of outstanding complaints has increased, impact of EPR implementation and winter pressures. Complaints policy and procedures have been reviewed and are being implemented. Briefing paper identifying specific actions and include divisional recovery plans presented to the Executive Management Team. Weekly monitoring of complaints continues. Process mapping of the complaints operational processes commenced April 2017 with rapid improvements / FGSA cycle throughout April. October 2017 - 2 x papers submitted to IMT / Patients re seen 6 months complaints and 30 day recovery August 17 - continue with weekly monitoring and assistance to be given when requested. New post created for quality assurance - commences September 17 June 2017 risk split into 2. Timeliness has improved in all areas apart from surgery. Additional help being looked at from PAUs.	Review - trajectories for improvement in place, backlog reducing. Review Exec January 2018 - to reduce from corporate to divisional register. November 17 - due to control in place re weekly monitoring, additional clinical staff now in complaints department and referral to QUOC the consequence has been reduced to minor. October 17 Amnesty on complaints responses for 2 weeks prior to EPR and during EPR roll out, has led to a further increase and delay. New staffing model being implemented from September onwards, number of complaints reduced. Patient remains surgery. Monitored on a weekly basis. September 2017	31/05/2018	Moderate	6
3193	09/03/2018	Fedell, Cindy	Trust Wide Risk	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.	31/08/2018	(3) May recur occasionally	(4) Major	High	12	(2) Do not expect it to happen again but it is possible	(4) Major	High	8	12 June 2018: No change awaiting 51 report completion before end of risk. 16 May 2018: Awaiting 51 report completion before closure of risk. 16 APR 2018: Mitigation actions all complete. Closure of risk deferred until after the 51 report is received at the April meeting of the Quality Committee. 14 MAR 2018: Completed 51 report to be reviewed at March Governance Committee and the risk to be closed thereafter. 7 FEB 2018: Correspondence identified for sending now processed. Additional monitoring and alerting in place. Closure of Serious Incident agreed with CCGs and now going through governance process. Technical root cause analysis agreed and report being drafted. Jan 2018: About 13,000 documents identified and reviewed and the CCG were sent directly to the relevant practice on the 12th December 2017 for usual review and general practice. A four stage process of review has been implemented for the remaining documents: a Stage 1 - Administrative review. All documents are reviewed to identify any actions that were required to be undertaken by general practice. a Stage 2 - Clinical risk review of all documents where potential actions were identified or where there was any uncertainty. a 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. a 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 period with appropriate audit, CCG and Medical.	Technical fix was applied along with augmented monitoring. A recovery plan was in place, including process to identify any potential clinical harm.	31/08/2018	High	8
3222	14/03/2018	Gill, Bryan	External Bodies	Deterioration in National Sentinel Stroke Audit Programme (SSNAP) performance (from D to S) leading to a risk that Stroke patients are receiving sub-optimal care thereby affecting their outcome.	31/07/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	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.	11/02/2018: High level meeting demonstrating significant improvements, mainly to Therapy and 'Front door' pathways. CCG have agreed funding to develop a single stroke service with flexible. Focus of improvement in the next month on acute and discharge pathways. Assurance paper reported to IMT and Quality Committee May 2018. 04/02/2018 Weekly recovery meeting in place, external work to Director and East Lancashire being completed. High level SSNAP meeting showing evidence of improvement in the majority of areas. CCG funding agreed to develop rapid stroke service with Anandale. Paper to IMT and Quality Committee in May 2018. 17/01/2018 Following meeting on the 17/01/2018 the main areas of work agreed. 1) Quality of Service, Specialist Lead Medical Director weekly update meeting with the Stroke Service Director. Operational issues. Specialist Lead Chief Operating Officer reviewing short, medium and long term challenges for the service. Agreed an action plan for the service including both areas of work. The plan is to plan to improve the delivery of a quality service for stroke patients (including recovery in the SSNAP performance indicators). 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, Clinical Board, IMT and external organisations through normal engagement channels.	31/03/2019	Moderate	6

3188	16/12/2017	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	30/06/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	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 recurring rather than poor clinical practice issue.	30/06/2018	Moderate	6
3184	09/01/2018	Gill, Bryan	National Target	There is a risk that patients are not being assessed for VTE and thereby at risk of hospital acquired VTE.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	(3) May recur occasionally	(3) Moderate	High	9	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 40% 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. May 2018: Weekly data consistently showing performance above 94.5% first week of May 2018 achieved the 95% standard. Regular feedback to wards to celebrate good performance and challenge non compliance in place. 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. 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 28/01/2018. February 2018 - Work undertaken to communicate and share daily VTE (patient-level) reports. Completed revisions to HII 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 90% 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 takes place as specific leads for all failure. Sharps Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee. April 2018 Update - group continues to meet, with targeted interventions. There has been some improvement but this has been hampered by changes in personnel with the frontliner (Bin Manufacturers) around training. WHC - doing 'lets talk unit on safe sharps disposal'. Video available for staff and being picked up on sweepers. Reporting to Quality and Safety sub committee by reception.	31/07/2018	Moderate	6
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	28/09/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Sharps Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee	28/09/2018	Moderate	6
3200	15/01/2018	Shannon, Sandra	CQC Visit	Baby abduction drill undertaken 15.1.18, the following risks were identified: See documents for list of risks	12/06/2018	(2) Do not expect it to happen again but it is possible	(5) Catastrophic	High	10	(2) Do not expect it to happen again but it is possible	(5) Catastrophic	High	10	15/1/18. Abduction real life scenario being tested this month with police. Additional admin staff approved in high risk maternity area to give greater coverage of door entry/egress monitoring. 26/4/18 Action plan for reducing risk being implemented. 02/02/2018 V2 Risk assessment. Security requirements nearly complete via access and exit routes. Abduction policy needs review. Staff guidance and awareness on going. Future abduction drills to be planned. Install censored neonatal/child security tags Alarm the fire door between labour ward and the birth centre. Alarm the door in the birth centre staff room. Sweep access on the double doors leading from the birth centre to labour ward. Secure the gate next to the gas cylinder storage. Install extra strobe lights in the vulnerable areas. Install an activation box in the antenatal clinic area. Buzzer release system linked to each area. Cascade the policy. Strengthen training in all areas. Out of hours abduction drill.	29/06/2018	Moderate	5
3132	17/08/2017	Claridge, Tanya	CQC Visit	There is a risk that clinical and non-clinical risks are not being adequately managed or escalated due to Divisions not being consistent or fully understanding the management and escalation of risk	30/06/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	(4) Will probably recur, but is not a persistent issue	(2) Minor	High	8	May 2018, A internal audit report was requested to understand the divisional approach to managing local clinical audit, including risk escalation. The findings were of limited assurance. While the divisions have focused on the development of risk associated with patient safety, this has not been translated across to other quality domains. This has resulted in a review and redevelopment of the development plan and a discussion with the effectiveness team in relation to better divisional engagement, as a result the target date for mitigation has been extended. April 2018: The Divisions are fully represented at a Risk Management Development Group. Risk registers are being proactively managed within the clinical Divisions. There are ongoing in relation to the management of risk associated with clinical audit which are subject to a detailed action plan that is being developed with the QDCs. A review of Quality Governance within the Divisions is scheduled for January 2019 to test the revised escalation processes. The CQC report will act as a source of assurance (positive or negative) in relation to this risk and as such it will be reassessed on receipt of the report. In addition an internal audit report looking at another quality domain (effectiveness) is scheduled to report immediately. March 2018: The risk treatment plan as described is continuing. Aired outcomes of CQC report.	28/09/2018	Moderate	4

3017	08/12/2016	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.	26/07/2018	(3) May recur occasionally	(3) Moderate	High		(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Staff training sessions available. Key trainers in place. Lifting aids available.	May 2018: It was agreed at DMT that additional funding for new WTE band 4 should be sought, however there is no additional funding for these posts. A discussion has been held with finance colleagues to try to identify the additional funding to support these posts. The risk remains the same. Recruitment to a planned vacancy (retirement) in the team has commenced. The date for planned mitigation has been changed as the business case process for this issue has taken over 6 months, and therefore delays in relation to effective mitigation have resulted. April 2018: A member of staff exceeded 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 0.2 WTE within existing risk budget, in addition the hours of one of the other established post has 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.	30/09/2018	Moderate	4
1739	02/06/2017	Claridge, Tanya	Escalated from Division	The is a risk to the safety and effectiveness of the care that our patients receive as there is inadequate control over, and assurance in relation to, the training of staff in the use of medical devices which may result in them being used inappropriately	31/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Process in place for new medical equipment entering the Trust to ensure adequate training is undertaken prior to use.	May 2018: the task and finish group reported back to DMT on 15th May 2018. The opinion of the group is that, without investment there is no additional mitigation that can be put in place. A different approach to this was discussed at DMT in relation to other health and safety posts. This review will be concluded by the end of July, as a result the target date for this risk has been changed until 30th September 2018. Feb 2018: Task and Finish Group has been established to report back to DMT 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.	30/09/2018	Moderate	4
3169	13/12/2017	Gill, Bryan	Business Continuity	There are a growing number of medicinal products, sourced on contracts, showing as out of stock with suppliers. The knock on effect of this is: 1. Potential delays to treatment whilst alternative stock is sourced. 2. Potential unavailability of some lines which can only be sourced from one supplier or where companies all source the raw ingredient from one supplier. 3. Medicines shortages of alternative lines as Trust's all look to source from the remaining suppliers. 4. Increased procurement costs due to buying off contract 5. Increased human resource time in searching out new contracts, order chasing, and processing of multiple orders.	30/06/2018	(3) May recur occasionally	(4) Major	High		(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	15	Regional shortages system put in place alerting Trusts to potential shortages and updating on when lines will come back into stock. Regional and national contracting strategies to try to ensure multiple suppliers for each product. Regional and national contracting strategies to assist new market entry. National work by the Commercial Medicines Unit working with Pharma to minimise shortages.	Continue to work with regional and national colleagues to ensure robust contracts are put in place for medication suppliers. Continue to support regional and national colleagues in market management. Continued involvement in the Regional Medicines Optimisation Procurement Collaborative Steering Group to ensure focus on shortages. Mitigation introduced but shortages remain a concern therefore to remain on the risk register until situation improves nationally.	30/09/2018	High	12
3240	15/05/2018	Shannon, Sandra	Escalated from Governance Committee	There is a risk that patients may suffer clinical harm as a result of a process failure in the RTT pathway. This has arisen as staff are not following the correct processes within EPR when recording the next steps in a patient pathway which means that patients may not have the appropriate outcome and follow up. The patients appear on the Non RTT process failure list.	29/06/2018	(3) May recur occasionally	(4) Major	High		(3) May recur occasionally	(4) Major	High	12	The patient cohort has been identified. It is the responsibility of Corporate Access Team to review the non RTT process failure list and implement the appropriate actions including updating EPR and moving the patient onto the correct workflow so the next steps in pathway can be implemented. The current rate of clearance is insufficient to meet the number of weekly additions to the list which requires further remedial action.	Agreed at GRC 24.4.18 & 4.18.3-open new risk (10.35.07 closed in March) 15/05/2018 - Process in place to monitor the additions and removals on a weekly basis via Weekly Planned Care Delivery Group. Additional stratification of the categories within the process failure list to be undertaken to enable prioritisation of clearance. Data Quality Group in place to work with Divisions to ensure appropriate work flow are adhered to. Work to commence with Education and Training team to identify additional training requirements.	29/06/2018	High	8
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.	31/07/2018	(3) May recur occasionally	(4) Major	High		(3) May recur occasionally	(4) Major	High	12	Careful attention to support on call schedule, cross-skilling, and documentation. Business continuity plans.	15 MAY 2016: Detailed business continuity plans under development. 16 APR 2016: LIM options appraisal activities on-going. 14 MAR 2016: Options appraisal on-going. 9 JAN 2016: 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.	31/12/2019	Moderate	4
1271	04/06/2008	Homer, Matthew	Corporate Objective	Injury to patients or staff due to lack of appropriate physical intervention training for appropriate staff.	31/07/2018	(3) May recur occasionally	(4) Major	High		(2) Do not expect it to happen again but it is possible	(3) Moderate	Moderate	6	OCT 2015: On track training in place. SEPT 2015: On track. JULY 2015: Training to be established to be in place by September 2015	May 2018 Update: Monthly meetings on-going to address the management of clinically related challenging behaviour and training gpp. Feb 2018: Work continues in this area and on 07 February 2018 Sarah Freeman, Head of Nursing (medicinal) led the first meeting to review the trust-wide management of clinically related challenging behaviour. A number of actions were agreed at this meeting as well as extended membership of the group to include divisional managers. The group will meet monthly to address the training needs and implementation of the meeting needs and reducing distress' framework to improve the management of clinically related challenging behaviour. All security staff receive certified physical intervention 4 day training with an annual refresher.	29/12/2017	Low	3

3104	31/05/2017	Fedell, Cindy	Trust Wide Risk	There is a risk of total or partial failure of the telephony system. This may impact on the ability to deliver clinical services. The ageing telephony system is now end of life. Manufacturer support has now ended and support is now provided by a third party supplier on a best endeavours basis. There is also an additional element of risk in that the current business continuity arrangements may not be adequate should a telephony system failure occur.	31/08/2018	(3) May recur occasionally	(4) Major	High	12	(3) May recur occasionally	(3) Moderate	High	9	Best endeavours support and maintenance contract currently in place reviewed annually.	15 MAY 2018: Work on the business continuity plans continue and are on track. 16 APR 2018: Telephony system upgrade options being reviewed. Budget being considered for inclusion of the 2018/19 capital plan. Business continuity plans with operational teams in development with expected approval July 2018. 14 MAR 2018: Vendor support offering being taken up. Final draft of business continuity plans produced. 7 FEB 2018: Continued support offering received from vendor for minimum of one year. Business continuity plans under second review. 9 JAN 2018: Technical options currently being assessed. Business continuity plans updated and awaiting approval.	29/03/2019	Moderate	6
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	Extreme	20	(3) May recur occasionally	(4) Major	High	12	Current firewall. Engagement with NHS Digital CyberCent 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.	15 MAY 2018: Cyber work plan in place with delivery being monitored through the IS Sub Committee. 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.	31/03/2019	High	12
2284	26/03/2014	Fedell, Cindy	Risk Management Steering Group	Risk of harm resulting from duplicate patient records on ICE	29/06/2018	(2) Do not expect it to happen again but it is possible	(5) Catastrophic	High	10	(2) Do not expect it to happen again but it is possible	(5) Catastrophic	High	10	Awareness and training of clinicians.	15 MAY 2018: Majority of amies using EPR to place Pathology orders so correct demographics in use. Some more complex areas such as sexual health still to be resolved. 16 APR 2018: ICE upgrade planning continues. 14 MAR 2018: Pathology interface to EPR now live. Upgrade to ICE is in the planning stage. Data quality in ICE will be in the scope of the upgrade. 07 FEB 2018: Pathology integration to EPR on track to go live in February 2018. Final testing near completion. 08 JAN 2018: Work to finalise Pathology results in to EPR continues. Solution undergoing final testing with planned go live in February 2018.	29/03/2019	Moderate	5
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	Extreme	15	(3) May recur occasionally	(4) Major	High	12	NDV 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 culture mechanisms in place is required in line 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 2017/18	March 2018: Pathology link in place as of March 2018. Currently all Pathology reports are being sent to EPR. Because of limitations within the systems some of the Histopathology and Microbiology reports are not displayed in EPR in a clinically safe way. Work is in progress to address this. The master record for Pathology reports remains the paper report. Clinical teams have been reminded of this.	29/06/2018	High	12
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	31/07/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	15	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	SEPT 15: There is a planned re-launch of the Safer Procedure workshops in line with the publication of the NPSA Alert - National Safety Standards for Invasive Procedures (NSISIPs). This will be a collaborative piece of work between the Quality Improvement Department and the Improvement Academy with support from NHS QI/IST. Data risk No. 2147 closed Sept 15 and merged with this risk	May 2018: Recent incidents in maternity, dermatology, cardiology and general medicine suggest on going risk with respect to safer procedure check list. Launching an improvement collaborative for all areas outside of theatre in June 2018. Full risk assessment being carried out by the risk team. January 2018: Recent snapshot audit in Theatre 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.	31/07/2018	Moderate	6
3192	08/01/2018	Dawber, Karen	Changes in legislation	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.	31/07/2018	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	Extreme	15	(5) Will undoubtedly recur, possibly frequently	(2) Minor	High	10	Safeguarding quarterly meetings. Safeguarding Adults Board.	Reviewed March 2018 - not had impact anticipated although still need to embed new systems and processes. Consequence reduced to a 2 and plan to review in 3 months with closure if no further impact. Task Force 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 A&D 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. May 2018 - Work continues to address as a whole system - not seeing impact first anticipated. Review in 2 months with a view to de-escalating from corporate RR	31/07/2018	Moderate	4

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	High		12	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	16	Line management arrangements in place with clear lines of responsibility and accountability SDPs in place June 2018: a review meeting was held with key staff members from the Division and good progress is being made with the actions within the action plan that they have direct control over. However the actions that depend on engagement with estates and facilities are not being progressed. This concern has been exacerbated as it is now clear that escalation of risk in relation to ventilation systems has not been effective through the E&F governance, or to the division In addition there has been a Newer Event in maternity theatre. It is suggested that this risk is formally reviewed in detail at the IS&RC meeting. The risk has been increased until complete evidence of mitigation in relation to ventilation systems is available. 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 Finances and BTHF QO are supporting staff Environmental checks and modifications have been undertaken by Estates Regular joint operational and estate meetings are in place A formal action plan is in place, encompassing the transactional estates and IPC measurements elevated together with	30/11/2018	Low	2
Principal risk: 1. Failure to maintain the quality of patient services, 2. Failure to recruit and retain an effective engaged workforce																		
2908	22/07/2016	Shannon, Sandra	Trust Wide Risk	Risk to 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.	13/08/2018	(3) May recur occasionally	(4) Major	High		12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Control Measures planned: Increase existing Infectious Disease Consultant Physician's PAs by 0.5 and review options for Agency within cap and working collaboratively with Airedale Microbiologists to join the OOH & on-call rota's. 14/7/18. One consultant post successfully recruited to. Awaiting start date. Additional capacity also provided by ID consultants. In the longer term alternative staffing models need to be considered. 16/4/18 recruitment of outstanding vacancies in process. Interview planned May 18 and there is one very interested suitable candidate. A locum is in post and additional clinical capacity is being provided by an ID consultant. The current mitigation will still need to continue even after this next recruitment. New 2017: The risk continues to be managed with existing mitigation plans in place Aug 2017: ID consultants together with locum providing service. Recent advertisement did not generate any interest so the Trust will advertise again jointly with A&H. Feb 2017 Appointed new microbiologist. Retired microbiologist providing temp support Control Measures planned: Increase existing Infectious Disease Consultant Physician's PAs by 0.5 and review options for Agency within cap and working collaboratively with Airedale Microbiologists to join the OOH & on-call rota's.	30/01/2018	Moderate	6
3050	13/02/2017	Shannon, Sandra	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 lists midwives would be expected to scrub, depleting the numbers on the shop floor.	30/06/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Recruitment in process Main theatre on call to help when emergency maternity theatres running paper presented to EMT June 2017, await BHP Theatre staffing approved, recruitment in place / waiting for starters On going discussions with surgery to look at a different model Re run of BHP 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 QDP in Q4 March - continue with recruitment campaign, mitigation date extended to 30/06/18. 2 a band 7 on each shift, some use of agency staff and small amount of permanent staff for elective lists	30/06/2018	Moderate	6
Principal risk: 2. Failure to recruit and retain an effective engaged workforce																		
3112	06/07/2017	Campbell, Pat	Corporate Objective	Failure to ensure that all eligible non medical staff have an appraisal. There is a risk that staff will not feel valued or engaged and will be unclear re their role, priorities and how this fits into the overall Trust objectives. There is a risk that turnover rates will increase if staff do not get feedback with no focus on their personal development and staff potentially not realising their full potential.	27/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		12	(3) May recur occasionally	(3) Moderate	High		Launch of 'Time to Talk' campaign in February which continues to be promoted through global email, education updates and conversations with leaders and staff. Simplified paperwork to aid the process and make more meaningful for both parties. Promotion of self-service and continue work to ensure data reporting is robust Targeted HR support in key areas. May 2018- change in reporting responsibilities - new reports being produced for division re compliance. Promotion of self service for reporting. Regular communications/case studies via L&H Talk. Training sessions in place for appraisers and appraisees, targeted support where areas under performing from QDP/HR. Use of data policy and extensive resources in place. As per control measures including reporting through divisional performance meetings against trajectories and escalation where divisions and departments are of target	28/09/2018	Moderate	4

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	Extreme	11	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	Contract resources continue on site. Recruitment continuing.	8 JUN 2018: HR consultation complete. New roles now in process set-up and to be recruited. 15 MAY 2018: HR change process progressing to plan. 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 IT 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 IT due to start 12/01/2018. 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.	28/09/2018	Moderate	6
Principal risk: 3. Failure to maintain operational performance																		
3150	06/10/2017	Shannon, Sandra	Trust Wide Risk	There is a risk that failure to achieve the Emergency Care access standard of 90% by September 18 and 95% by April 19 will result in the monitor risk rating and therefore impact on reputation and that the Trust will not receive the financial bonus for achieving the standard.	16/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	11	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	ECS Improvement programme in place reporting to the Bradford Improvement Programme. Trust also involved in action on A&E programme.	15/7/18 improvement continues on an upward trajectory. Pathway changes continue to be implemented. 25 April 18 Pathway and process changes implemented. Improvement continues on an upward trajectory. 15 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 OGD is currently providing focused support to urgent care. The Acting GOC 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	Moderate	4
2681	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	29/06/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	11	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	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 data submissions	May 2018: a paper detailing the current status of the work to develop quality control principles and practice across all data submissions was presented to Executive Management Team in May. There is now a comprehensive suite of submissions managed by informatics that have identified quality control. This work is now being extended to all submissions. A further update of this is due at EMT in June 2018. At this point a new risk assessment will be undertaken. 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 i.e. 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 involves a review in case of a full recovery	30/01/2018	Moderate	4
Principal risk: 4. Failure to maintain financial stability																		
3236	14/05/2018	Shannon, Sandra	Cost Improvement Programme/Financial Balance	There is a risk that the data quality issues that have arisen since the implementation of Cerner EPR will impact on the Trusts ability to accurately record activity and as a consequence impact on the income expected.	16/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	16	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	EPR SOPs in place. Training provided for staff on the correct application of EPR to record activity. Additional support for DQ improvement is being provided by an external consultancy - Cymbo. Robust governance arrangements are in place monitored through Bradford Improvement Programme	A data quality recovery plan is in place and a central performance team has been created to lead on the implementation of the data quality recovery plan. A full set of KPIs have been agreed and tracked through the Cymbo DQ dashboard. Robust governance arrangements are in place monitored through Bradford Improvement Programme	30/11/2018	Moderate	6
3251	08/06/2018	Homer, Matthew	Trust Wide Risk	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	Extreme	16	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	16	JUNE 18: 1. The cash & liquidity position is managed and monitored by the cash committee with updates provided to the Finance & Performance Committee. 2. Curtailment of the Capital programme in 2018/19 to limit the cash outlay 3. Continued sourcing of cash releasing efficiencies 4. Additional measures taken to improve financial control in the immediate and longer term. 5. Updated reporting arrangements to Finance & Performance Committee on the cash and liquidity, with trajectory and projections signposting risks and generate corrective action	JUNE 18: 1. The cash & liquidity position is managed and monitored by the cash committee with updates provided to the Finance & Performance Committee. 2. Curtailment of the Capital programme in 2018/19 to limit the cash outlay 3. Continued sourcing of cash releasing efficiencies 4. Additional measures taken to improve financial control in the immediate and longer term. 5. Updated reporting arrangements to Finance & Performance Committee on the cash and liquidity, with trajectory and projections signposting risks and generate corrective action	31/01/2019	Moderate	6

2893	19/06/2016	Fedell, Cindy	Trust Wide Risk	EPR - Inability to achieve the expected benefits realisation affecting the organisation's financial position.	26/09/2018	(4) Will probably recur, but is not a persistent issue	(5) Catastrophic	Extreme	20	(4) Will probably recur, but is not a persistent issue	(5) Catastrophic	Extreme	20	EPR benefits lead for the programme is undertaking a detailed review of the realisable benefits to assess viability.	15 MAY 2018: Work progressing to align with updated improvement Programme 17 APR 2018: 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 programme 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	31/08/2018	High	10
3248	08/06/2018	Homer, Matthew	Corporate Objective	Failure to maintain financial stability and sustainability in the current economic climate with the Trust facing a continued financial challenge associated with cost inflation, increased demand for services and Commissioner affordability.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	16	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	16	JUNE 18: 1. 2018/19 Bradford Improvement Programme governance and performance management arrangements, to performance manage delivery of the CP. Divisional CP trackers in place with fortnightly updates reported internally and to NHS Improvement. 2. Divisional Performance Management & Review meetings, to performance manage delivery of the planned run rates following the budget re-serv exercise undertaken for 18/19 3. Standing Financial Instructions and Scheme of Delegation	JUNE 18: To deliver the financial plan/control total for 2018/19 the Trust has a savings requirement/cost improvement target of £25.5m. 1. 2018/19 Bradford Improvement Programme governance and performance management arrangements, to performance manage delivery of the CP. Divisional CP trackers in place with fortnightly updates reported internally and to NHS Improvement. 2. Divisional Performance Management & Review meetings, to performance manage delivery of the planned run rates following the budget re-serv exercise undertaken for 18/19 3. Key to securing the 2018/19 Financial plan will also be the delivery of the planned income levels which will be supported by the new introduced weekly activity trackers.	31/03/2019	High	12
3249	08/06/2018	Homer, Matthew	Corporate Objective	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.	31/07/2018	(3) May recur occasionally	(4) Major	High	12	(3) May recur occasionally	(4) Major	High	12	JUNE 2018: The updated governance arrangements introduced as part of the Bradford Improvement Programme have strengthened the Quality Impact Assessment and CP evaluator and approval gateway process.	JUNE 2018: The updated governance arrangements introduced as part of the Bradford Improvement Programme have strengthened the Quality Impact Assessment and CP evaluator and approval gateway process.	31/03/2019	High	9
2151	24/09/2013	Homer, Matthew	Corporate Objective	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.	31/07/2018	(3) May recur occasionally	(4) Major	High	12	(3) May recur occasionally	(4) Major	High	12	OCT 2015: The governance arrangements for improvement initiatives have been strengthened and now include a refined Quality Impact Assessment and Financial Impact Assessment. This process is managed by the FMO. OCT 2015: The Foundation Trust has submitted a high level improvement plan to Monitor with the final plan required by 31.12.15. The proposed financial recovery period is over 4 1/2 years with a break even position planned for 2019/20. The planned recovery trajectory includes investment into QES and proposes a realistic level of annual CP delivery (just over 3% per annum). The Foundation Trust will continue to undertake quality impact assessments for all appropriate CP's throughout the period of improvement.	APR 2018: The Improvement Plan for 2018/19 inclusive of the CP requirement is currently being finalised with all schemes requiring a full QA and FIA to be approved before commencement of the scheme. Adherence to the process will be managed through the Bradford Improvement Programmes with further process assurance throughout the year assured via the Quality Committee and the Audit and Assurance Committee	31/03/2018	High	9
3046	03/02/2017	Fedell, Cindy	Changes in legislation	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.	31/07/2018	(2) Do not expect it to happen again but it is possible	(4) Major	High	8	(3) May recur occasionally	(4) Major	High	12	Moved software products to a more streamlined architecture in order to minimise the risk and reduce costs.	15 MAY 2018: Work continues with licensing reconciliation activities with specific suppliers. 16 APR 2018: Work continues with licensing reconciliation activities. 14 MAR 2018: Work on going to ensure compliance with remaining software estate. 7 FEB 2018: All known licensing issues addressed from devolution of licences. Review of new software implementations being undertaken. 9 JAN 2018: Agreement reached with software vendor and order placed to correct licensing position. Audit closed.	31/07/2018	Moderate	6
Principal risk: 5. Failure to deliver the required transformation of services																		
3110	26/06/2017	Gill, Bryan	Business Continuity	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.	26/06/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	12	(4) Will probably recur, but is not a persistent issue	(2) Minor	High	8	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. Bi-weekly safety meetings taking place.	March 2018: detailed quality report reviewed at Quality Committee in February. Assured that progress is being made. ID consultants meeting deferred due to winter pressures. New planned for first of March 18. JV Governance meetings are now operational. 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.	26/06/2018	Moderate	4
3060	03/03/2017	Dawber, Karen	Trust Wide Risk	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. 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 2018. The feed from the IPC team	30/09/2018	(5) Will undoubtedly recur, possibly frequently	(4) Major	Extreme	20	(5) Will undoubtedly recur, possibly frequently	(2) Minor	High	10	Airedale microbiology will telephone results for MRSA, C.diff, faecal coliform, norovirus, rotavirus. Results for other alert organisms e.g. VRE, other resistant organisms. TB would depend on the microbiologists indicating a risk on the Fordean system and then the IPC nurse will have access to this Fordean list - however this is a new system to the microbiologists so they may miss some alerts. This mitigation also alerts IPC nurses from their clinical duties to clerical because of the need for manual data handling.	The risk will resolve once a reliable iCNet feed from Fordean is established Update May 2017: Near miss, regarding MRSA bacteremia result. Need to rethink mitigation urgent meeting with IT required. Update May 17: Unable to reboot system following their down of IT systems - software is out of date and cannot be security patched. Update June 2017 - has been rebooted but Fordean link not operational	30/09/2018	Moderate	4

2380	22/08/2014	Gill, Bryan	Directorate Objective	Pending a decision from NHS England regarding the status of BTHFT as an arterial centre the Trust continues to operate a non-compliant vascular service. Because of our non-compliant status there is a risk that our services might no longer be commissioned and the trust will lose vascular (arterial) surgery.	31/08/2018	(2) Do not expect it to happen again but it is possible	(4) Major	High		(2) Do not expect it to happen again but it is possible	(4) Major	High		A vascular strategy and business case for a hybrid theatre has been developed and given provisional approval pending the decision by NHS England. The Trust continues to be involved in discussions with NHS England and other local NHS Trusts to positively influence the decision making process. May 2018: WYAT decision to recommend BTHFT as the second arterial centre NHS associated commissioners now undertaking due process. February 2018: WYAT on track to make a decision at the end of March 2018. BTHFT Senior staff closely involved in the vascular programme. No new emergent risks have come to light but a decision on the timetable for implementation of the standard, notably the hybrid theatre could significantly influence the decision.	31/12/2018	Low	3
Principal risk: 6. Failure to achieve sustainable contracts with commissioners																	
2991	21/10/2016	Fedell, Cindy	Trust Wide Risk	EPN - Inability to fulfil contractual obligation in relation to information, reports, standards, etc following implementation of EPN. Loss of confidence in the Trust from other healthcare organisations leading to damage to organisational reputation.	06/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		Established current reporting requirements and working through design/test of reports. Manual process in place and backup via data warehouse 12 To ensure any reports that cannot be run by the system are generated whilst problem is rectified to ensure business continuity. Reporting Board in place. 08 JUN 2018: Full SUS submission completed in May 2018 as per plan. CDS not completed for Month 1 on agreement with Commissioners and Finance team. 15 MAY 2018: CDS reports on track for submission in May 2018. 16 APR 2018: All reports complete. Data validation ongoing with plan to issue CDS in May 2018. 14 MAR 2018: RTT reporting now being completed with remaining technical issues with the supplier to resolve. Diagnostic reporting work continues. 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). 9 JAN 2018: RTT reporting issues are being resolved with EPN vendor. To be completed and tested beginning of February 2018.	31/07/2018	Moderate	6
3250	06/06/2018	Homer, Matthew	Corporate Objective	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.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme		(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme		JUNE 18: 1. Regular monitoring and performance management of the indicators and activity plans with in-built triggers both internally and externally through the contract reporting and meeting structures and through internal performance review meetings with Divisions. 2. Early discussions with the CCO and NEDS highlighting risk areas and where necessary involving the appropriate contract levels. 3. Internal reporting arrangements in place for both contractual and CQUIN indicators with monthly performance reporting to the Performance Committee/Board of Directors identifying actions and mitigations. 4. Monthly CQUIN steering group in place to monitor and manage delivery of in year indicators 16 JUNE 18: 1. Regular monitoring and performance management of the indicators and activity plans with in-built triggers both internally and externally through the contract reporting and meeting structures and through internal performance review meetings with Divisions. 2. Early discussions with the CCO and NEDS highlighting risk areas and where necessary involving the appropriate contract levels. 3. Internal reporting arrangements in place for both contractual and CQUIN indicators with monthly performance reporting to the Performance Committee/Board of Directors identifying actions and mitigations. 4. Monthly CQUIN steering group in place to monitor and manage delivery of in year indicators.	31/01/2019	Moderate	6
Principal risk: 7. Failure to deliver the benefits of strategic partnerships																	
2975	09/09/2016	Fedell, Cindy	Trust Wide Risk	Key information and resources for staff on both the public website and staff intranet are unable to be kept up to date or have new information added in a timely, professional manner because of the ongoing lack of web support staff. There is therefore a risk of staff, patients and the public not being able to access accurate information/knowledge they require in a timely way.	31/07/2018	(3) May recur occasionally	(2) Minor	Moderate		(3) May recur occasionally	(2) Minor	Moderate		Some staff (number unknown) with varying degrees of knowledge/skills to add/update information themselves but may not have capacity to do so reliably. Attempts being made to recruit new staff but as yet unsuccessful. 15 MAY 2018: Review of vacant web post underway with a view to advertise revised job by the end of June 2018. 16 APR 2018: New external facing web site is now live with easier management. Continued review of internal resources. 14 MAR 2018: BETA testing of the new external web site continues with switch over being planned. Skills transfer to Trust staff underway. 7 FEB 2018: BETA version of new external web site now live. Internal resource requirements under review. 8 JAN 2018: Web developer and trainee in post supporting the intranet. External web site development nears completion.	31/10/2018	Low	2
3090	24/04/2017	Holden, John	Board of Directors Meeting	There is a risk that local (i.e. Bradford) integrated care proposals destabilise existing BTHFT arrangements without compensatory benefits for service users. In signing the Alliance Agreement (and related documents)the Trust could commit itself to developments further downstream which may create unforeseen financial and operational risks, and impact on staffing and facilities (especially at community sites).	02/05/2018	(2) Do not expect it to happen again but it is possible	(4) Major	High		(2) Do not expect it to happen again but it is possible	(4) Major	High		BTHFT is represented at Exec level on the current governance groups i.e. Bradford Accountable Care Board and the Bradford Provider Alliance 8 Out of Hospital Programme Board, also Integrated Management Board. Mar 18: FCH workshop now scheduled for 17 April. Diabetes outcomes framework agreed after discussions re: BTHFT concerns, and assurances re time period before any potential penalties apply, including a break clause. Chief Nurse & Dir of Strategy involved in discussion with CCG, alongside Division of Medicine colleagues, re "out of hospital" programme (especially re: location & management of community beds) Feb 18: BTHFT has offered to host a workshop to review the emergence of Primary Care home (PCH) to ensure there is a shared understanding of risks opportunities and engage constructively with primary care, care trust and VCS partners.	30/04/2018	Moderate	6

3091	24/04/2017	Holden, John	Board of Directors Meeting	<p>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 BTHFT operational/finance/service viability and so hinder delivery of clinical strategy.</p> <p>WYHP: West Yorks & Harrogate Health & Care Partnership WYAAT: West Yorks Assoc of Acute Trusts</p>	02/05/2018	(3) May recur occasionally	(4) Major	High		12	(3) May recur occasionally	(4) Major	High		12	<p>BTHFT contributed to the development of the original STP and has been actively represented on various governance groups (e.g STP Leadership Forum, WYAAT Committee in Common), policy/professional groups (e.g Medical Directors Group, Directors of Finance Group) and in the formulation and monitoring of programmes of work (e.g Chair of West Yorks Cancer Alliance Board) etc.</p> <p>March 2018: ICS Expression of Interest submitted 16 Feb after SLEG discussion in which BTHFT Exec supported direction of travel but highlighted immaturity of processes and controls. BTHFT ongoing involvement in drafting discussions re SLEG MDQ, and in specific programmes e.g to determine location of vascular arterial centre.</p> <p>February 2018: WYHP has formed a "System Leadership Exec Group" (SLEG) and is developing an MDQ to address questions about its governance, in readiness for a proposed expression of interest to the national A&Us to enable WYHP to become an "Integrated Care System (ICS)". BTHFT attends the SLEG and will stipulate the text 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.</p>	30/04/2018	High	8
3153	23/10/2017	Holden, John	National Guidance	<p>There is a risk that NHS's proposals for consolidating pathology services in west Yorkshire around a single Hub (Lends) and 5 spokes would put at risk the JV for pathology with Airedale NHS FT. This would have significant financial risks (breach of contract) and the trust would lose influence over the future of the pathology service, with adverse consequences for service to patients.</p>	02/05/2018	(3) May recur occasionally	(4) Major	High		12	(3) May recur occasionally	(3) Moderate	High		9	<p>Two responses submitted to NHS. First a joint letter from WYAAT CEOs & MDs setting out the existing WYAAT pathology programme and why WYAAT will look at the configuration of services to best suit the population. Second a joint letter from AFT and BTHFT setting out the success of the JV and the implications if this were to be changed.</p> <p>Feb 18: through the JV Board, BTHFT has lobbied NHS to agree to a separate discussion which recognises the strengths of the JV relative to the proposed alternative. This was scheduled for January 2018 but NHS were unable to attend. In addition the JV is conducting discussions with other NHS organisations who may wish to join the JV, strengthening its market position. In the meantime BTHFT continues to be active in the WYAAT internal programme of pathology discussions, to ensure any West Yorkshire-wide proposal adequately reflects BTHFT concerns.</p>	30/04/2018	Moderate	6
Principal risk: 8: Environment																			
3142	07/02/2017	Shannon, Sandra	Risk Assessment	<p>A structural survey and report was commissioned by E&F to determine the structural integrity of the floors of F 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 the floors would be replaced.</p>	09/07/2018	(3) May recur occasionally	(5) Catastrophic	Extreme		15	(3) May recur occasionally	(5) Catastrophic	Extreme		15	<p>None at present.</p> <p>E&F concerned that potential structural issues remain - to be discussed at CRAG 31.08.17 meeting.</p> <p>14/5/18 Business case to be considered at business case review group. A further structural assessment has been considered. 17 April 18: A business case has now been presented to DM7 which was approved subject to financial sign off. March 18: Business case to be considered for off site storage February 2018: Business Case to be presented to the next Business Case Review meeting.</p>	31/05/2018	Low	2
Principal risk: 9: Non-compliance with regulations																			
3223	13/03/2018	Claridge, Tanya	Escalated from Integrated Risk Register Review Meeting	<p>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.</p>	31/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High		12	<p>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.</p> <p>June 2018: All actions described below have been completed in the context of the completion of an action plan related to a recent HTA inspection. Evidence supporting completion of the actions is expected by 30/6/18 to support closure of this risk on the corporate risk register. Treatment plan: March 2018 The Task of the Human Tissue Group need reviewing The Trust needs to communicate with the Coroner as to the storage of tissue connected to Coroner 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</p>	31/07/2018	Low	3
3068	15/03/2017	Claridge, Tanya	Legal requirement	<p>There is a financial, reputation and safety risk as the Trust is non-compliant with the Carriage of Dangerous Goods Regulations 2009.</p>	31/07/2018	(3) May recur occasionally	(4) Major	High		12	(3) May recur occasionally	(4) Major	High		17	<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>May 2018: the action plan is now in place, with a focus on major/critical actions being completed by the end of July 2018. At this point it may be possible to review and amend the level of risk related to compliance. This is because the moderate and minor actions represent a focus on optimising the compliance of the Trust 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. 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 and Jan 2018. Internal Audit review to be undertaken within 2017/18.</p>	31/07/2018	Moderate	6
Principal risk: Yet to be assigned a principal risk																			

3135	17/08/2017	Shannon, Sandra	External Bodies	There is a risk to the Trust's reputation through its non compliance with BRE for fire testing of cladding on the Decontamination block	31/05/2018	(1) Cannot believe that this will ever happen again	(3) Moderate	Low	(1) Cannot believe that this will ever happen again	(3) Moderate	Low	Fire safety policy and procedures. Delivery against NHS mitigation plan	March 2018: NHS agreed management plan. Awaiting notification from NHS regarding funding of proposal. Local mitigation arrangements in place. February 2018: NHS agreed management plan. Awaiting notification from NHS regarding funding of proposal. Local mitigation arrangements in place. October 2017: Have communicated with NHS as requested within the given timescale and are awaiting response to the management plan. Sept 17: Awaiting report from Fire Safety Engineer. Additional measures in place to comply with stage 2 of NHS plan. Liaising with NHS for development of stage 3 of plan which NHS have endorsed	31/05/2018	Low	2
2841	24/03/2016	Shannon, Sandra	Legal requirement	Potential of prosecution due to poor segregation and contamination of waste across the organisation	12/06/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	(3) May recur occasionally	(4) Major	High	All clinical waste in high risk areas consigned as 'yellow' waste Re-training of waste staff on correct consignment of waste Changes to waste disposal rooms at maternity and ENT to allow better segregation	14/2/18 Options for training provision have been reviewed and a paper is to be taken to EMT at the end of May proposing different options for training. In the meantime face to face training is still available with targeted training where any concerns arise. 17/04/18 Training attendance is lower than required. A new training approach is being developed; primarily non face to face methods. 7/2/18 a number of actions have been completed including training, SOPs and policy updates. Action plan in progress Jan 18: TOR written for waste group Internal audit report received and action plan being followed	30/04/2018	Moderate	6
3242	24/05/2018	Horne, Matthew	Escalated from Governance Committee	The risk of reputational damage and the risk of Trade Unions balloting members to recommend the commencement of industrial action as a result of the Foundation Trust considering the feasibility of creating an Alternative Delivery Model (ADM) for the delivery of Estates and Facilities services.	31/07/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	(4) Will probably recur, but is not a persistent issue	(4) Major	Extreme	Continued engagement with key stakeholders, staff groups and staff side representatives throughout the development phase of the Final Business Case (FBC) which is due to be presented to the July meeting of the Board of Directors. This risk was discussed at IGRC on 23.5.18.	Agreed to add to the CR at the IGRC 23.5.18 The development of the Final Business Case that considers the feasibility of creating an ADM will include a detailed engagement plan with key stakeholders but in particular key staff groups and staff side representatives. Post Board decision (July) and subject to approval, the plan will be enacted and full consideration given to the employment model options.	31/07/2018	Moderate	4
3255	11/06/2018	Holden, John	Board of Directors Meeting	The trust has an on-going programme of collaboration with Airedale Foundation Trust. The 3 key areas within this programme that present risks are as follows: 1.Back of agreement between the two trusts (Bradford Teaching Hospitals NHS Foundation Trust, BTHFT and Airedale Foundation Trust, AFT) on the nature and scope of collaboration 2.Collaboration proceeds with a scope that BTHFT does not believe is optimal for improving services or fulfilling its clinical strategy 3.Collaboration proceeds in line with a scope acceptable to BTHFT but does not improve services to a level acceptable to the Trust The impact of these 3 areas is as follows: 1.Reduced mental health assessment between	31/07/2018	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	(4) Will probably recur, but is not a persistent issue	(3) Moderate	High	For the 3 key areas within this risk, the following control measures are in place: 1.Ongoing conversations occur between senior exec leadership across the two organisations to get agreement on collaboration scope 2.BTHFT Partnership committee oversees the strategic direction of the programme including scope, and how the trust should seek to act if scope is not acceptable 3.Built joint programme management and governance between BTHFT and AFT has been established and oversees the day to day operation of the programme to ensure its successful delivery. Staff roles assigned to oversee the delivery of the programme with scope for increased resource if required.	The following actions are being undertaken which will help mitigate the risk: Stroke lead to be appointed to oversee stroke service collaboration as part of the programme, along with clinical lead. This will help ensure services currently being examined by the programme deliver on the benefits required by the trust. Independent review of existing clinical dependencies to be funded by CCG to outline an approach to optimising current arrangements, including identifying areas of clinical risk. This will help ensure future work of the programme addresses areas of service need as well as helping define the scope of the programme. Meeting arranged between AFT and BTHFT chair and CEOs to get clarity and agreement on programme scope	31/07/2018	High	9
3235	14/05/2018	Dawber, Karen	Escalated from Integrated Risk Register Review Meeting	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.	30/06/2018	(5) Will undoubtedly recur, possibly frequently	(2) Minor	High	(5) Will undoubtedly recur, possibly frequently	(2) Minor	High	*Ongoing assessment of acuity to ensure agreed staffing levels are met and where they are not what the impact is. *Safety Huddle / Daily RAG / SAFECARE *Clear escalation process in place and followed when agreed staffing levels not met. *Continue with campaigns and recruitment to non-registered roles. Reported via Workforce Committee, recruitment and retention plans *Weekly Chief Nurse Team Meeting *Review of NCB safe and sustainable actions	May 2018: To continue with actions currently in place, including recruitment of newly qualified staff in September / October 2018 (phase 1) delay. Monitor effectiveness of plan via workforce committee, replaces risk ID 2995	30/11/2018	Moderate	6
3244	25/05/2018	Fedell, Cindy	Sub Committee Risk Register	There is confusion of where patient information can be found which may impact care and treatment, arising by the backing of scanning mini packs that will not be scanned between 6 December 2017 and 15 April 2018.	31/07/2018	(3) May recur occasionally	(4) Major	High	(3) May recur occasionally	(4) Major	High	Scanning bureau will locate and ensure paper medical information is available. Communication in the form of an SOP has been circulated informing staff of the dates when information has not been scanned and the process to retrieve clinical documentation.	13 JUN 2018 - Plan in place and actions being taken to enable the Bureau to scan in a timely way. Actions to be completed by end June 2018 and weekly monitoring will continue to ensure sustainability. Agreed at IGRC 23.5.18 to add to CRB. Reduction in amount of paper received in mini packs which will speed up scanning process and enable backing to be available via Evolve. Revalidation of staff to Scanning. To work with areas to ensure that information is being documented in a standard and consistent way so can be located easily. To review what is built or could be built into EPR as information within electronic record. To understand whether a contextual link is available from the patient record in EPR directly into their Evolve record	31/07/2018	High	8