

Board of Directors: 12.07.18
Agenda item: Bo.7.18.8

Report from the Integrated Governance and Risk Committee

Presented by:	Clive Kay, Chief Executive	Author:	Tanya Claridge, Director of Governance and Corporate Affairs
Previously considered by:			

Key points	Purpose:
1. This paper provides an overview of the work of and outcomes from the Integrated Governance and Risk Committee in May and June 2018	To note and gain assurance

Executive Summary:
<p>This report has been written to summarise the work and outcomes of the Integrated Governance and Risk Committee. The Committee has met on two occasions since the last Board of Directors in line with its terms of reference (23/5/2018 and 20/6/18). It was quorate on both occasions.</p> <p>The Integrated Governance and Risk Committee provides a governance infrastructure for review and challenge associated with the management of and mitigation of risks being managed within the Corporate Risk register. This report provides, by exception, risks on the corporate risk register which were subject to active consideration and decision making, with the rationale for that consideration and the outcome of the decision making at the Committee meetings.</p>

Financial implications:
Yes – Income & Expenditure

Regulatory relevance:

Monitor:	Risk Assessment Framework
	Code of Governance
	Quality Governance Framework

Equality Impact / Implications:	<p>Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what is the mitigation against this?</p>
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Other:	CQC fundamental standards
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Strategic Objective: <i>Reference to Strategic Objective(s) this paper relates to</i>	To be a continually learning organisation
	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 collaborate effectively with local and regional partners

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Date	Risk ID	Description	Rationale for consideration	Decision/commentary	Outcome
23/5/2018		Risk associated with consideration of an alternative delivery model	New risk, allocation of risk	Risk to be assessed and added to Estates Risk Register	Risk ID 3242
20/6/2018	3242	Risk associated with consideration of an alternative delivery model	Changed situation	Risk to be closed and two separate risks to be assessed and added as required to the risk register and escalated for consideration at the Integrated Governance and risk Committee 1. Risk of industrial action 2. Reputational damage	Action due by 20/7/2018
20/6/2018	3255	Risk associated with collaboration with Airedale Foundation Trust	Risk escalated from June Partnership Committee	Risk to be formally assessed specifically in relation to clinical governance	Action due by 20/7/2018
23/5/2018	2236	Risk associated with the integrity of the patient record in EPR	Nature of risk changed	The risk was closed and the risk associated with scanning mini packs in relation to delays, storage and accessibility assessed and added to the corporate risk register.	Risk ID 3244
20/6/2018	3244	Risk associated with the management of the scanning of mini packs and	Increasing clinical concern	The risk was reassessed and the score increased due to ongoing issues in relation to consent and information governance issues	Action due by 20/7/2018
23/5/2018	3222	Risk associated with deterioration in the quality of service for stroke patients	Nature of risk changing	It was confirmed that this now involved broader work with Airedale. However it was decided that the risk should remain as described as present with the option of considering the benefit of managing two stroke service related risks in the future after a further period of risk assessment. This risk assessment would involve considering the transactional elements related to the conduct of the national audit and a separate assessment of the service interface between the Trust and Airedale NHS Foundation Trust	Risk to remain as worded and mitigated but kept under regular review
23/5/2018	3133	Risk associated with the failure to meet statutory timescales for providing health reports to education	To be closed	This risk was closed on the corporate risk register. The number of referrals has decreased and the service has made operational changes to provide capacity to meet demand.	Divisional risk 2383 to remain open and managed through the divisional risk register
23/5/2018	2150 2151 2157 3012	Risks associated with failure to deliver the Trust's Financial Plan 2017/18	Reduction in score at year end	All financial risks reduced in score for the year end. The committee agreed that these risks (2150, 2151, 2157 & 3012) would be closed and new risks for the coming financial year would be assessed and opened on the Corporate Risk Register	New risks have been assessed and added to the Corporate risk register
23/5/2018	2417	Risk associated with diagnostic tests not being acted upon in a timely way	Longstanding risk	The risk requires a full risk assessment in light of the functionality offered by EPR and other clinical informatics systems in the Trust	Risk assessment underway: Action due by 20/7/2018
23/5/2018	1739	Risk associated with sub optimal compliance with Medical Devices Training	Long standing risk with co-dependencies with moving and handling risk	The wording for this risk will be re-considered alongside a risk assessment of medical devices and moving and handling training	Risk assessment underway: Action due by 20/7/2018
23/5/2018	3184	Risk associated with the failure to meet VTE assessment standards	Evidence of change in performance and effective mitigation	The Trust is now consistently hitting the 94% and above target for VTE assessment. Agreed to await sustained performance before reassessing the risk and reallocating for clinical divisional management and mitigation	Next review date set, ongoing monitoring through divisional governance
20/6/2018		Risk associated with the outcome of the Joint	Review of external visits register	A new risk relating to EVR No 173 - Joint Advisory Group (JAG) visit to	Action due by 20/7/2018

Date	Risk ID	Description	Rationale for consideration	Decision/commentary	Outcome
		Advisory Group (JAG) accreditation visit to the Endoscopy Unit		Endoscopy Unit should be assessed and the EVR to be updated with the risk ID	
20/6/2018		Risk associated with the potential issue of enforcement notices in relation to maternity services	Intelligence from CQC inspection and engagement Recent Never Events	A new reputational risk will be assessed in relation to the impact and implication of any regulatory action against the Trust in relation to maternity services	Action due by 20/7/2018
23/5/2018	3169	Medication shortages	Escalation from Division		Action due by 20/7/2018

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 Zew backlogs. Individual review of all patients over 62 days undertaken weekly and management plan agreed. 6/18 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 Zew 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. National 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 / FGSAs 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. Maintained 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 in therapy and 'front door' pathways. CCG have agreed funding to develop a single stroke service with flexible. Focus of improvement in the next months on acute and discharge pathways. Assurance paper reported to IMT and Quality Committee May 2018 04/02/2018 Weekly recovery meeting to plan, 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 2) 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 collection 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 (HPI), 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	<p>Infection control audits are in place. However, there are some issues with this see previous risk.</p> <p>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.</p> <p>There is an inconsistency in how care plans are requested and generated - this needs further embedding as we continue to implement the EPR.</p> <p>Our audits and manual checking processes are showing that staff are not adequately recording cannula scores, cannula insertion and other HPI in the EPR. A PROGRESS review has shown that individualised care plans are not being completed also.</p> <p>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 HPI - we are not seeing any statistically significant changes, this would indicate that this is a recurring rather than poor clinical practice issue.</p>	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	<p>The Trust has consistently failed to meet the 95% compliance target for VTE assessment following the introduction of a new system in 2016. The EPR was expected to improve the system for undertaking and monitoring the meeting of this standard but as yet has not been realised. Data became available at the end of November 17 which demonstrated 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.</p> <p>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.</p> <p>April 2018: Full update paper presented at Quality Committee (Q3.18.15). Continued progress at 94.5%. Outstanding work on high throughput areas and cohorting rules.</p> <p>March 2018: Rate for February 2018 93.95%, on trajectory to meet 95% standard by 31/03/2018. Update on comprehensive improvement to be presented and discussed at Quality Committee on the 28/01/2018.</p> <p>February 2018 - Work undertaken to communicate and share daily VTE (patient-level) reports. Completed revisions to HPI 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.</p> <p>October 17 - Detailed action plan developed. Task and finish group set up to monitor weekly compliance. Working with CHFT on cohort rules given single EPR. Direct communication taken place as specific leads for all failure.</p> <p>Sharp Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee.</p> <p>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. WISC - doing 'lets talk on site on sharps disposal'.</p> <p>Video available for staff and being picked up on sweepers.</p> <p>Reporting to Quality and Safety sub committee by reception.</p>	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	<p>Sharps Injury group meeting. Campaign in place across the Trust. Discussed at Health & Safety Committee.</p> <p>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. WISC - doing 'lets talk on site on sharps disposal'.</p> <p>Video available for staff and being picked up on sweepers.</p> <p>Reporting to Quality and Safety sub committee by reception.</p>	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	<p>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.</p> <p>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.</p> <p>Install censored neonatal/child security tags.</p> <p>Alarm the fire door between labour ward and the birth centre.</p> <p>Alarm the door in the birth centre staff room.</p> <p>Sweep access on the double doors leading from the birth centre to labour ward.</p> <p>Secure the gate next to the gas cylinder storage.</p> <p>Install extra strobe lights in the vulnerable areas.</p> <p>Install an activation box in the antenatal clinic area.</p> <p>Buzzer release system linked to each area.</p> <p>Escalate the policy.</p> <p>Strengthen training in all areas.</p> <p>Out of hours abduction drill.</p>	29/06/2018	Moderate	5
3132	17/08/2017	Claridge, Tanya	CQC Visit	The 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	<p>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 risk a discussion with the effectiveness team in relation to better divisional engagement, as a result the target date for mitigation has been extended.</p> <p>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 10 gaps 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 2018 to test the revised escalation processes. The QDC 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.</p> <p>March 2018: The risk treatment plan as described is continuing. Aired outcomes of QDC reports.</p>	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		6	(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 EMT 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		12	(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 EMT 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 EMT 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 EMT by end of April 2018 with recommendations. Aug 2017: Process is in place for new medical equipment entering the Trust which ensures adequate training is undertaken prior to use. Proposal being drawn up by Clinical Engineering to address medical equipment in use.	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		12	(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		12	(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 (10.3.17 closed in March) 15/05/2018 - Process in place to monitor the additions and renewals 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		12	(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		12	(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 matrons. 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 areas 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 nears 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	12	(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 GO 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	Cardige, 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	12	(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 programmes completed and to be reviewed by Executive Management Team to initiate detailed work. 9 JAN 2018: Benefits work initiated including alignment of work, data, and planning	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 service 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-set 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-set 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 evaluation 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 evaluation 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 4-12 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. 14 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. Now planned for End 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	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 culture, 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 diverts 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 shut 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		8	(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		12	(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 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 (or 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		16	(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. 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		6	(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		8	(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 Integrated Management Board. Mar 18: FCH workshop now scheduled for 17 April. Diabetes outcomes framework agreed after discussions re: BTHFT concerns, and assurances in 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 operations/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	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.	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. February 2018: WYHP has formed a "System Leadership Dev 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.	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	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.	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.	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 E Block. This was due to the amount of medical records stored in the building. The report has found that the floors are significantly understrength for the current usage of the building and recommends immediate structural repairs / works to support the floors. This will cost a significant amount of money and 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	None at present. 15 E&F concerned that potential structural issues remain - to be discussed at CRAG 31.08.17 meeting.	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 BMT 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.	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	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.	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 Talk 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	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	12	All relevant departments within the Trust have been made aware of the serious breaches identified above. 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.	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.	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	14/5/18 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, replace 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 so 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