ID	Risk	Rating (initial)	Likelihood (current)	Consequence (current)	Rating (current)	Rating (Target)	Opened	Review Date	Risk Lead	Risk Category	Risk Type	Division	CBU	Specialty	Controls	Gaps in controls	Assurance	Gaps in assurance
Clinical																		
894	There is insufficient assurance that a robust and fully functional medical devices training programme is in place, particularly with devices classified as 'high risk' on the medical devices database. There is also insufficient assurance that competency assessments are in place and in use within clinical services across the organisation and that this information is being captured centrally through L&D.	9	Likely	Moderate	12	3	11/09/2013	25/07/2017	Johnstone, Clare	Clinical	Medical Devices	Corporate Services		Medical Devices	Medical Devices Policy E-Learning Clinical Courses (on OLM) Clinical training courses (classroom) available Competency assessments for a select number of devices	E-learning packages are currently unavailable for some medical devices Training packages and competency assessments are not available for all devices	Availability of training records for medical devices programmes Evidence through the Medical Devices Audit programme Compliance with NHSLA 5.5 as reported through KPIs to Medical Devices and Product Selection Group	
926	The principles of asepsis are not always observed and uniform standards of safe care in relation to Aseptic Non Touch Technique (ANTT) are not uniformly applied, increasing the risks of infection.	9	Possible	Moderate	9	6	08/10/2013	31/05/2017	Johnstone, Clare	Clinical	Infection Prevention	Corporate Services		Infection Prevention	Updated and approved ANTT policy (IPC 04) ANTT audits completed by IP team as part of annual IP work programme ANTT competency assessments required every 2 years- to be completed by line managers and recorded as part of PDAR ANTT e-learning package available	Staff not completing ANTT eLearning programme as required Notification of need to complete not available on individual training compliance matrix Denominator not available on OLM	Quarterly e-learning uptake figures reported to IPG Annual competency assessment completion figures reported to IPG	Denominator data unavailable therefore accurate quarterly uptake reports not available

928	If drug administration is not carried out correctly on Jade and Marjory Warren wards then patients may come to harm	12	Possible	Moderate	9	4	09/10/2013	28/04/2017	Ali, Sulekha	Clinical	Clinical Treatment	North Division	Inpatient Rehabilitation (Barnet and Harrow)	Inpatient Rehabilitation	Action plan for improvement of drug round safety. Introduction of drug round tabards. new storage cabinets for medications. Competency assessment for all nurses for drug administration. Performance management for repeat drug or drug chart errors. New Drug chart designed and implemented Handover of drug chart between individual nurses for individual patients at each shift change Matrons to ensure action plan is enforced by each individual nurse and performance manage where necessary Charge nurse to check agency nurse drug charts at least twice per shift	None	Drug charts being audited weekly by trust pharmacist. Staff instructed to log all drug incidents on Datix	None currently identified
980	Risk that we are not conducting self-medication assessments and promoting self-medication at some of the bedded services so that when patients are discharged they are not able to cope with taking medicines.	9	Possible	Moderate	9	3	31/10/2013	31/07/2017	Butt, Arfana	Clinical	Administration	Corporate Services		Medicines Management Team	Self-medication Policy in place and training delivered	Service managers responsibility to organise training for staff. Training was conducted last year since then staff changes may mean that some staff have not received the training	Audit against SOP. Sample of 5 patients per unit. To be reviewed at MMG.	Not all units have patient own drug lockers with individual keys.
994	Inaccurate Information on discharge documents relating to medicines from our bedded services resulting in unintentional change to medication and miscommunication of intentional medication changes.	12	Possible	Major	12	4	07/11/2013	31/05/2017	Butt, Arfana	Clinical	Medicines Management	Corporate Services		Medicines Management Team	Medicines reconciliation completed on admission to bedded service. Screening of discharge prescriptions by unit pharmacists prior to dispensing. Documentation of medication changes on discharge summaries.	Infrequent visits to the unit by the pharmacist may result in miscommunication and poor documentation of medication changes on CLCH discharge summaries/TTAs. There is not an official mechanism in place for care providers to report medication errors with discharge summaries back to CLCH bedded services. For patients discharged back to their own homes with DN input there is no resource available for pharmacists to perform medicines reconciliation.	Pharmacist responsible for final screen of discharge summary and documentation of medication changes at PLK, Alex Rehab, Barnet beds & pembridge. Datix incidents completed for unsatisfactory discharges from CLCH bedded services	Not aware if mechanism to discuss improvement in discharge documents is in place. There is not an official mechanism in place for care providers to report medication errors with discharge summaries back to CLCH bedded services

1070	If CLCH continue to have problems recruiting Health Visitors, as well as retaining current Health Visiting workforce employed by the Trust, alongside the agency cap, the ability to deliver the full healthy Child Programme and safeguarding caseloads will be compromised, which could lead to a clinical risk, low staff morale and damage to reputation.	9	Likely	Moderate	12	6	06/02/2014	26/05/2017	Pearce, Sheila	Clinical	Financial Risk	Children's Division		Health Visiting	Nursery Nurses recruited to increase skill mix Pro-active recruitment and retention processes, Borough specific HV adverts. Monthly reporting into Divisional IQPR and review of controls measures, minuted. Close monitoring of KPI measures and action of any breeches, escalated to senior managers and IGM. HV Service Transformation Programme commenced. Weekly conference calls with DDO/ADQ/HR and Finance Business Partners to monitor agency use	recruitment of health visitors is an issue across London and there is competition with 19 other providers	Working closely with HR and Recruitment Business partners around recruitment and retention strategy and timescales when recruited. Rolling advert and 6- 8 weekly interviews Monthly divisional IQPR and feedback re: recruitment process and KPI measures	None identified
1084	If we cannot recruit enough suitable staff and the temporary staffing are unable to fill vacancies on Marjorie Warren ward we may not achieve safe staffing levels and patients may be harmed. (Compromise to patient safety due to continuing difficulties achieving safe staff level on Marjorie Warren Ward. The ward is persistently short of trained nursing staff and of band 6 staff to be in charge. This is contravening CLCH staffing directive and national standards for safe staffing and is impeding work to increase skill and competency of nurses on the ward)	15	Unlikely	Minor	4	4	06/03/2014	28/04/2017	Vijayakumar, Prabha	Clinical	Service Delivery	North Division	Inpatient Rehabilitation (Barnet and Harrow)	Inpatient Rehabilitation (Marjory Warren)	trust band continuing to attempt to source trained nurses recruitment to vacant posts ongoing and in progress Flexing therapy support workers to support nursing when shortages occur Matron working clinically when necessary to support safe staffing Weekly Quality Action Team Local managers informed of staff shortages and these are recorded on DATIX	None currently identified	Daily staffing report to Director of Nursing Minutes from the Quality Action Team	None currently identified

1091	CLCH does not receive a reliable, complete and timely information flow form maternity units in relation to Mother's Hepatitis B status and this impacts on the HV services ability to deliver the Hep B package of care and therefore a clinical risk of the child not receiving the full immunisation programme.	9	Unlikely	Moderate	6	3	19/03/2014	31/03/2017	Cody, Angela	Clinical	Communication	Children's Division	0-19 Services Barnet, Brent, Harrow and FNP Barnet	Health Visiting	Monthly MDS Hepatitis reported at the Divisional Governance meeting Hepatitis B pathway written and reported through MDS	There is no robust governance framework e.g. Hepatitis B is not on the dashboard, and there is no performance report no robust automated data flow in relation to Hep B	DG&QM and minutes reviewed	None identified
1119	If local staff do not carry out regular required inspection/maintenance of defibrillator and emergency call bags, then equipment may become out of date and unfit for use; we may miss the opportunity to save life. Risk also of damage to reputation. Risk of non-compliance with regulating bodies, such as CQC. An improvement notice from the CQC would seriously compromise FT application.	15	Rare	Catastrophic	5	5	29/05/2014	30/06/2017	Johnstone, Clare	Clinical	Medical Devices	Corporate Services		Resilience and Compliance Team	Identified responsible person for each defib bag/pack List of all sites with defibs and location of spares/replacements Daily checks and checklist; indicates expiry dates Budget has been secured for equipment upkeep and all equipment has been ordered and replaced as needed Resus officer employed to deal with any issues on a daily basis		Monthly monitoring meeting with the resus officers Twice yearly audit to ensure devices and defibrillators are being checked daily	We lack up-to-date, regular information/assurance from localities/business units that daily checks are being carried out. The resus monitoring meeting is currently not minuted
1133	It has been identified through the medical devices audits that there is not a robust system in place for implementing external quality assurance (EQA) on point of care testing devices (POCT) across the organisation. The Risk Group will need to advise on whether there is clinical need for EQA within the organisation before actions can be made.	9	Likely	Moderate	12	3	18/06/2014	31/08/2017	Johnstone, Clare	Clinical	Medical Devices	Corporate Services			Internal quality control for glucometers is in place MHRA Device Bulletin-Management and use of IVD POCT devices (DB2010(02)) Training in the use of glucometers (which includes internal quality control checks) Updated MHRA Guidance in the use of IVD POCT devices , 2013	Non-compliance of MHRA Guidance in the use of IVD POCT Devices 2013 Not having a recommended external quality assessment (EQA) scheme in place The Trust does not have a local POCT policy		

1139	If staff do not attend Infection Prevention training, there is a clinical risk to patients and a reputational risk to the trust for non-compliance with the Hygiene code and CQC regulations.	12	Likely	Moderate	12	3	19/06/2014	27/04/2017	Daley, Marcia	Clinical	Infection Prevention	Corporate Services			Infection Prevention Work Programme based on the Hygiene Code Statutory & Mandatory Training Policy launched and available to all clinical staff. Infection Prevention eLearning and classroom sessions available	Staff not attending required training	Monthly attendance league tables sent by L&D to DDOs and CBU managers Quarterly reports to IPG, then to Quality Committee and Board	
1184	Patient care needs may not be met by the service, as a result of decreased staffing levels due to vacancies, significant levels of sickness (long term) and inability to obtain bank or agency cover.	12	Likely	Moderate	12	3	09/09/2014	31/07/2017	Molloy, Cora	Clinical	Staffing Levels	Inner Division	Community Nursing - Tri Borough		Temporary staffing alerted to the urgency of securing bank/agency nurses Cross cover from teams where there are gaps in perceived safe staffing levels organised	Temporary staffing still unable to secure backfill of bank/agency nurses	Recruitment plan in place and on-going recruitment taking place Staff sickness being managed under the managing sickness policy	Current sickness levels may be different to previous month's sickness monitoring levels, due to time lag in reporting
1220	BAF Risk: Risks to operational functions and quality related to monitoring of electronic health records.(Specifically S1)	15	Possible	Major	12	8	30/12/2014	31/03/2017	Ashley, Louise	Clinical	Data Quality	Corporate Services			Ongoing training at a service level Monthly performance reporting PID, QOG and CSOG for SystmOne & data reports Use of S1 is now embedded as business as usual	Reported KPI's may not fully represent the actual activity	ELT review performance and conduct audit of KPIs and need DDOs/DIN have oversight Delivery of performance is within target Performance review monthly packs Clinical system changes now complete and programme structure closed	Nil gaps in assurances
1224	There is a risk that within the current structure not all elements of SLT can be delivered as commissioned. This could lead to increased waiting times, delayed delivery of highly specialised services and an inability to deliver support to wider teams (both internally and externally to CLCH).	9	Unlikely	Moderate	6	3	21/01/2015	28/04/2017	Laffey, Patrick	Clinical	Service Delivery	North Division	Long Term Conditions (Barnet, Harrow and Herts)	Speech and Language Therapy Service - Adult	All Barnet Adult SLT budgets all sit under one cost centre. Allocation meetings occurring via SystmOne for SLT ICS Service. Service now falls under one CBU with a dedicated Service Manager. Locum SLT's in place. Implementation of new ways of working. Demand and Capacity exercise completed. 1 further band 6 to recruit to. SLT team now more stable . 1 x band 6 SLT started 1st June 2015. Service now falls under one CBU with a dedicated Service Manager Locum SLT''s in place Implementation of new ways of working Demand & Capacity exercise completed	Further recruitment being held up as budget in BCM005 not correct (due to inpatient post and finance journal system errors). Once budget clear SLT Manager will skill mix range of bands to achieve what is necessary to deliver service.	KPI's (waiting lists) are down for HEFT, Parkinson's, but increased last month for ICS due to leave. Demand for SLT on MWW at Finchley was underestimated. SLT service keeping records of referrals. However there is currently no mechanism for SLTs inputting into Jade and MWW to record their referrals and activity on SystmOne as bedded services do not record each patient activity on SystmOne. Capacity & Demand paper - showing low activing per WTE (see above)	None currently identified

1229	Increase in demand and reduction in capacity (due to clinics being cancelled by Royal Free) has led to increased waiting times (above contract) in Barnet MSK. This could lead to reduced quality of care (particularly for long waiting patients) and damage to reputation. The above relates to ICMSK service.	9	Unlikely	Moderate	6	3	06/02/2015	28/04/2017	Abdulla, Valerie	Clinical	Clinical Treatment	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	MSK Physiotherapy	Interim acting up into the Operation Lead post Formal meeting with booking office/ CBU manager/ Service Triage has been de-commissioned (as of 1st April 2015) which should result in extra clinician time 3 locum physiotherapists brought in to reduce wait times There is dedicated MSK admin resource Task and Finish group set up Successful Recruitment of CLCH ESP Triage of high risk patients Regular review of current waiting list Extra clinics have been arranged with specialist ESP (inc on a Saturday) Weekly DMT meetings There is better management of ESP service level agreement to ensure that staff sickness absences are covered by the Royal Free	Currently there is conflicting waiting time data	Monthly KPI on waiting times DMT minutes Minutes of formal booking office meeting (1st meeting 31st March)	
1265	Risk of increased waiting times, reduction in quality of care and damage to reputation following an increase in demand within the phlebotomy service in Barnet.	12	Rare	Moderate	3	3	18/03/2015	31/05/2017	Abdulla, Valerie	Clinical	Service Delivery	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	Phlebotomy	Established email address for patients to get an appointment Increased admin capacity Amended voice message so that patients are aware of the likely queuing time Walk-in clinics have been established for fasting patients Activity discussed at weekly DMT/ Monthly Board meeting/ team meetings Support from patient experience team to patients Successful recruitment of additional phlebotomists (currently no temporary or agency phlebotomist)		Daily/ Weekly reports on telephony/ staff activity Minutes of DMT/ Board meetings PALS report	

1291	Systm One - allocation issues resulting in missed patient visits , issue affecting Community Nursing and Phlebotomy service.	12	Unlikely	Moderate	6	3	13/04/2015	28/04/2017	Cupid, Wendy	Clinical	Clinical Treatment	North Division	Community Nursing Services - Barnet	District Nursing	Additional SystmOne support in place 3 days a week Weekly SystmOne Trust wide meeting SystmOne surgeries have been set up for each CBU- completed All patients to have a care plan in place Band 7/ senior nurse ensures that all patients are allocated to an HCP on SystmOne Requirement for additional SystmOne training for all staff (floorwalker) CBU SystmOne standard operating procedure Additional training has been held for out of hours staff (Enfield DN service)	Reconfiguration on SystmOne to ensure that phlebotomy allocation does not remove the nursing visit for patient	Minutes of weekly SystmOne meeting Confirmation of issues from IT service desk	Actions log following SystmOne surgery Spot check audit to ensure all patients have a care plan Copy of SOP
1292	All relevant NICE Guidance must be assessed. The risk is that clinical service teams will not complete NBAF forms and return to the NICE Core Group within the agreed timeline, therefore assurance will not be able to be provided to the Board or Commissioners on relevant reports that this has been achieved. This will result in an inability to provide to the Board or Commissioners that this has responsibility has been met, and that patients may not have received optimal care based on the best available evidence.	12	Rare	Moderate	3	3	16/04/2015	31/05/2017	Medhurst, Dr Joanne	Clinical	Service Delivery	Corporate Services	Corporate Services	Strategy and Performance	Summary of inadequate assurance generated at the end of the clinical effectiveness group. This is to be circulated in email to the ADQs and the Divisional Directors. These areas are to be added to the agenda of the monthly divisional quality meeting.	This relies on operational teams responding in a timely and effective manner.	Monitored by the NICE core group Reported to the clinical effectiveness group Overseen by the MD	

1312	Non-compliance of CAS alert: NHS/PSA/W /2015/004 -Managing Risks During The Transition Period To New Iso Connectors For Medical Devices could lead to an inability to deliver therapy due to device incompatibility, use of adapters, device shortages, logistical issues and awareness problems.	9	Possible	Moderate	9	6	08/05/2015	29/06/2017	Gata-Aura, Roveena	Clinical	Medical Devices	Corporate Services	Corporate Services	Medical Devices	Enteral Feeding Steering Committee Adult Enteral Feeding Policy Paediatric Enteral Feeding Policy Adult Nasogastric Policy	Contingency plan during Abbott's patient management database software upgrade Identification of affected medical devices	Minutes of the steering group policy	
1324	There is currently no documented process for to manage high risk patients in the Podiatry service. This could lead to delays in appointments which could lead to major patient harm.	8	Unlikely	Major	8	4	05/06/2015	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Podiatry	Daily clinical triage SOS clinics in K&C and Barnet (appointment system only, if you are currently registered under our service) Working group has been set up Documented process for to manage high risk patients Increase in booking rotas and rapid access clinic. Service specific triage guidelines for diabetic and high risk patients in place and being followed	Service specific triage guidelines for diabetic and high risk patients to be reviewed with Tier 3	SI's / Incidents/ PALS	Audit to ensure quality of triage Audit of current use of guidelines for treatment of high risk patients All staff to have signed to say they have read the SOP
1349	Patients developing Grade 3 or 4 Pressure ulcers as a result of inadequate preventative care by staff. Impact serious harm to patients	16	Rare	Major	4	4	06/07/2015	28/04/2017	Githinji, David	Clinical	Pressure Ulcer - newly identified	North Division	Inpatient Rehabilitation (Barnet and Harrow)		All Leads spot check and check patients skin integrity daily Weekly conference calls for ward managers and Matrons with CBU Manager for monitoring of PU incident Matrons are accountable to CBU manager on weekly basis Pressure ulcer policy in place Daily MDT meeting		Board KPI will show a sustained improvement of zero avoidable pressure ulcers Completed Action plan Weekly audit of pressure ulcer care plans	Audit of use of 'Care Delivered' form Copy of training records for PU training and OSCE's

1356	During the data migration, 2586 patient records had NHS numbers removed and became fragmented between the Child Health Unit and the Community Units. And 2278 further records had NHS number removed without fragmentation. There is a risk that end users will not be able to search for their patients via the NHS number and this may result in further duplicate registrations and that information added to fragmented records will not be visible to all clinicians, which may impact patient safety and quality of care.	12	Rare	Major	4	4	13/07/2015	31/05/2017	Pearce, Sheila	Clinical	IT Systems	Children's Division			The number of affected records has been precisely and accurately identified	The proposed solution was not achieved by the S1 project closure	No information has been lost and the affected records have been precisely and accurately identified	
1363	Due to the national shortage of BCG vaccine NHSE/PHE have revised the vaccination guidance. As a result CLCH will no longer be offering the BCG vaccination except to babies meeting the new criteria, once the Patient Specific Directive process is agreed with CCGs and NHSE/PHE. There is a clinical risk and a reputational risk to the HV service.	16	Possible	Major	12	4	30/07/2015	25/05/2017	Pearce, Sheila	Clinical	Clinical Treatment	Children's Division		Health Visiting	PHE/NHSE guidance and criteria PSD process agreed, in place for Harrow with clinics commencing in April 17	PSD process not yet resolved for all boroughs. None identified	Being monitored at Divisional Management Team	
1382	During the transition phase of the SLT transformation programme the reduction in the specificity of the EHC (Education, Health and Care) plans, could lead to families challenging the changes, resulting in reputational damage.	12	Likely	Moderate	12	9	24/09/2015	30/06/2017	Ghalley, Mav	Clinical	Service Delivery	Children's Division	Speech and Language Therapy	Speech and Language Therapy	Individual case discussion with the local authority SEN managers Service Level agreements with schools (Current SLAs H&F: 1, WM: 5, RBK&C: 1)	No Gaps identified	Monitored through supervision with the Therapist. Termly coordinators meeting to monitor service development and changes	No Gaps identified

1383	Risk to patient safety due to a lack of robust CLCH processes and training within the podiatry service in relation to ordering, supplying and administering medications in line with the Podiatry Exemptions list regulatory annotation.	9	Possible	Moderate	9	3	29/09/2015	28/04/2017	Klinkhamer, Frits	Clinical	Medicines Management	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	Podiatry	College of Podiatry Exemption List outlining medications that can be used Working Parties addressing gaps in processes and training to support Exemption List use Existing out of date guidance to support some areas on the Exemption List List of podiatry staff who trained pre and post 1998 including updates received	Develop SOPs to support specific areas of practice involving medication Medicines Management policy to be updated in relation to Exemption List processes in CLCH Training to be provided annually including updates Lack of competency frameworks to support practice involving medications Lack of educational leadership and support within the services Lack of a list of podiatry staff who trained pre and post 1998 including updates received	There have been no incidents reported in relation to Exemption List practices Minutes from working party and podiatry steering group meetings	Audits of SOPs (once in place) List of staff trained
1406	Patients are at risk of being harmed, due to both national and local standards of care not being followed for the management of leg ulcers. This is due to a lack of trained and experienced nurses, as a result of difficulties in recruitment.	16	Rare	Major	4	4	15/10/2015	31/07/2017	Dang, Jo	Clinical	Clinical Treatment	Inner Division	Community Nursing - Tri Borough		1.All patients have up to date Doppler assessments and appropriate care plans recorded on System one 2.Patients who are now seen at home and if suitable for compression bandaging are receiving this treatment 3.Ongoing teaching from TVN's in regards to refresher training 4.Leg Ulcer Clinic maintained from existing community nursing establishment from each team 5.Programme of education for junior staff to work through competencies and can now work according to national and local guidelines 6.Rota organised of senior nurse / team leads who are all competent in leg ulcer management including Doppler and new patient assessment as of 1st Sep 16	1. Negotiation is ongoing with H&F CCG about TVN service (although the TVN's as of Dec 2016 have started to accept new patient referrals for H&F patients	1. Locality assured that appropriate senior nurses are rota to work in Leg Ulcer Clinic and they manage day to day activity such as writing prescriptions for wound dressings etc. 2.TVN documentation/templates also available on SystmOne for easy auditing 3.Monitoring by locality leads reporting to ADQ.	Inadequate monitoring would only be identified following the identification of an SI.

1422	Reduced leadership in LD staffing cohort raises ongoing risk of disconnect of team members from CLCH systems, processes and support. Also reduces lines of accountability and governance for team management.	6	Unlikely	Minor	4	2	20/10/2015	28/04/2017	Abdulla, Valerie	Clinical	Communication	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	Learning Disability Community Team (Barnet)	band 7 team leads are being supported to link into CBU manager and CLCH systems head of service in post who will be picking up responsibilities supported recruitment for post across LBB and CLCH 8a health lead post is out for advert	possible lack of suitable candidates Re-structure within LBB has the service manager post and he has left re-structure of HoS role may mean additional personnel changes	being actively monitored and tracked by CBU manager confirmation of recruitment to post	75 due for re-negotiation. issues can be clarified and addressed as part of this. Due Mar 16
1423	Risk to patient safety, reduced performance and staff wellbeing due to dosing within the anticoagulation service currently being delivered by one qualified clinician which means that the services is not covered during planned/ unplanned absence therefore clinics have to be cancelled.	6	Unlikely	Moderate	6	3	21/10/2015	31/07/2017	Prevost, Audrey	Clinical	Business Continuity	Inner Division	Specialist Nursing		Process map of cover for when clinical lead is on leave to be developed Training GP's and practices to provide medication if required Monitoring performance to ensure clinician takes leave during low activity periods Performance Meeting Monthly team meeting Band 5 in post going through competency to achieve the dosing qualification Notification to all GP's when staff member takes annual leave Care plans will be discussed with patients with recommendations what to do if community dosing is not accessible	Training of second permanent staff member	Minutes of team meeting Minutes of performance meeting Copies of performance papers	Copy of competency framework

1437	Insufficient assurance that loan medical equipment used across the Hertfordshire Sexual Health and Family Planning service is safe, fit for use and within service date. Therefore posing a patient safety risk and risk to staff as well as non-compliance of the Medical Devices Policy and the MHRA's Managing Medical Devices (April 2015) guidance document	9	Unlikely	Moderate	6	3	02/11/2015	28/04/2017	McCann, Una	Clinical	Medical Devices	North Division	Sexual Health	Sexual Health Services	Equipment database for CLCH owned equipment available on CLCH Hub Medical Devices Policy (CLCH)		Risk Assessments for Health and Safety in the Workplace Medical Devices audit schedule	
1438	BAF Risk: The Trust is acquiring significant new clinical services and following transfer of these the Trust may identify risks to quality and compliance within the services which will require remedial actions. These could trigger regulatory breaches.	12	Unlikely	Major	8	6	02/11/2015	30/04/2017	Ashley, Louise	Clinical	Service Delivery	Corporate Services			Quality Meeting with Commissioners Post transfer "mock inspections" Funding secured for additional compliance post during integration and post integration (Sept 16) Continued inspections of new clinical areas	Standard operating procedure for Quality Governance (integration of services)	Review of KPI for new divisional teams at divisional board and trust level Quality inspections (+\-) Scrutiny of current assessments Assessment of current practice and performance re. education Assessment & successes of current quality improvement programs and evidence of effective integration of programs to align with CLCH quality and clinical strategies	
1448	If the band 5 vacancies for Central London DN Team are not filled then DN team leads and deputy team leads will have to cover this workload and are therefore unable to support new and existing band 5 nurses and students to develop essential nursing skills, resulting in poor quality care.	12	Possible	Major	12	4	17/11/2015	31/03/2017	Aluku Obwoya, Alice	Clinical	Clinical Treatment	Inner Division	Community Nursing - Tri Borough		2. Practice nurse commenced in March 2016 providing support to junior nurses 3. Completed recruitment process of band 7 team leaders since Sep 16 1. Use of band 5 bank and agency nurses	difficulty getting available bank and agency nurses		

1475	If all GP's do not switch on 'Share Out' within system one, then clinicians are unable to view the full record leading to compromise in care delivery.	8	Likely	Minor	8	2	30/11/2015	31/01/2017	Ebenezer, Peter	Clinical	IT Systems	Inner Division	Integrated Long Term Conditions - Inner Boroughs		Discussed and minuted at the Diabetes partnership group Diabetes clinical lead aware This has been raised with I.G Evidence of good clinical practice throughout the team (i.e. the teams follow up where the full clinical record is not available) Work programme in place across CLCH & CCG IT teams There is now a list of all G.P's who have not switched on 'Share Out'	Completion of work plan.	Copy of minutes of meetings Clinical audit	
1481	If Referral Facilitation Service (RFS) do not appropriately refer patients to the Hounslow diabetes service then there will be a delay in treating both current and new patients	16	Unlikely	Major	8	4	04/12/2015	28/04/2017	Cassidy, Helen	Clinical	Clinical Treatment	Inner Division	Long Term Conditions	Diabetes Services	Hounslow Diabetes referral process now in place Hounslow Diabetes referral pathway agreed CLCH staff do triage incorrect referrals Regular 1:1 meetings with RFS manager CLCH contract meeting with Hounslow CCG CLCH staff are briefed and aware of new process	None currently identified for CLCH	Minutes of Contracts meeting Emails re. 1:1 contact with RFS manager Incident reports	Audit of referral process
1488	There is currently not sufficient provision in the Child Development Team at Chelsea and Westminster hospital within SLT to meet the demands for assessment of children over 5 in Social Communication clinics to support diagnosis of Autistic Spectrum Disorders. This is a clinical risk.	12	Likely	Moderate	12	3	10/12/2015	26/05/2017	Tilley, Ciara	Clinical	Service Delivery	Children's Division	Speech and Language Therapy	Speech and Language Therapy	NICE CG 128 Autism in under 19s: recognition, referral and diagnosis	Service Capacity	CBU Quality and Performance monthly meeting	None identified

1511	If the only 4 substantive Physio posts in the tri borough LD team, together with the existing OT and SLT vacancies are not recruited to then this will lead to a compromise in clinical treatment.	15	Rare	Moderate	3	3	17/12/2015	28/04/2017	Ebenezer, Peter	Clinical	Service Delivery	Inner Division	Long Term Conditions	Learning Disability Community Team (Central Division)	1. Locum in place at band 6 level in Westminster 2. K/C have provided the paperwork for recruitment to band 6 PT but it has not proceeded further	1. Currently no recruitment of a locum sole band 7 PT in place for K/C despite paperwork being sent 2. No active recruitment for the sole band 6 PT in K/C 3. Band 6 is going on 6 weeks leave in Jan 2016	Finance is available	LD vacancy rate does not appear to be on the radar as a significant vacancy Communication between the 2 organisations could be clearer Local LD network may become politically active in raising lack of access to therapies Lack of handover of patients, no local knowledge of systems and processes for individual therapy professions , no list of vulnerable patients
1519	If district nurses are not trained in constructing a medicine chart from a prescription then then patients could come to harm.	9	Rare	Moderate	3	3	30/12/2015	28/04/2017	Cupid, Wendy	Clinical	Medicines Management	North Division	Community Nursing Services - Barnet		Edgware nurses are now trained Currently drug chats are all signed by G.P's Transcribing policy in place All staff now trained	Training to be aligned with policy and NMC transcribing standards All DN's in all localities to be competency assessed. Liaise with 1 GP who is refusing to sign drug charts	Copy of transcribing policy	List of all staff who have completed competencies List of all staff trained Written confirmation confirming CLCH policy does not contradict NMC guidelines
1528	Student clinicians have been given smartcards giving them access to SystmOne to document care without any formal process for confirmation of competence. There is currently no accessible function on SystmOne for mentors to countersign student entries. Placing us in direct breach of CLCH clinical record-keeping policy.	12	Likely	Moderate	12	6	29/01/2016	28/02/2017	Stevenson, Tracy	Clinical	IT Systems	Corporate Services	Corporate Services	Learning Team	Clinical Record keeping policy Process in place whereby students are permitted to view records alongside practitioners	No clear monitoring of the distribution of smartcards and suitability when providing to students	progress report via education forum Reported via clinical systems register	

1534	The volume(approximately 850)of new routine patients not seen within 84 days means we are not meeting contractual obligations and may also impact on patients foot health.	12	Rare	Major	4	4	02/02/2016	28/04/2017	Abdulla, Valerie	Clinical	Clinical Treatment	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	Podiatry	Clinic appointments are now available 4 months in advance New patient to follow up patient ratio amended to enable waiting times to be met for new patients 'Short-schedule' clinics set up to further enable waiting times to be met. Package of care to discharge new patients Regular meetings are in place with set agenda between bookings office and podiatry All referrals are triaged before they go into the 'partial booking letter to be sent' folder, meaning there should be no high risk patients who have not had a partial booking letter. Podiatry steering group in place Podiatry SOP in place	Implementation of the discharge package of care for new patients	Waiting time KPI's Performance report to Divisional Board Monthly CBU report to the Board	Copy of the reviewed SOP
1541	If CLCH Hounslow Diabetes service is unable to successfully step up podiatric ulcer patients to the acute setting, then this puts additional pressure on the service and could lead to delays in treatment for patient's.	12	Possible	Moderate	9	3	10/02/2016	31/03/2017	Ebenezer, Peter	Clinical	Clinical Treatment	Inner Division	Long Term Conditions	Diabetes Services	There is an agreed documented process to 'step up' and 'step down' patients to the acute setting Weekly consultant led MDT meetings Increased capacity within the acute setting (West Middlesex) Agreement that if West Middlesex do not have capacity, that we can refer to another acute setting	West Middlesex are not at full capacity to take patients	Copy of the documented process for step up and down Minutes from MDT meeting	Email communication from service lead to CBU manager on progress

1552	Unable to store medication according to the safe storage of medicines policy. This is due to not having authorised lockable medicines cupboards within a locked room.	12	Rare	Minor	2	2	15/02/2016	30/06/2017	Horn, Jenny	Clinical	Medication - not involving Controlled Drugs	North Division	Walk In Centres / Urgent Care Centres	Urgent Care / Walk In Centre	2. Drugs now delivered from pharmacy in a storage box sealed with a tie	Final solution to the problem to have area behind nurses station partitioned as room to store medicines in and to buy approved metal drug storage cupboards/cabinets		
1567	If new patients are referred to the District Nursing services out of hours then there is a risk that the standard referral information will not be available to staff which could compromise patient care and staff safety.	9	Possible	Moderate	9	6	09/03/2016	28/04/2017	Cupid, Wendy	Clinical	Clinical Treatment	North Division	Community Nursing Services - Barnet	West Locality - Edgware	Updated referral template for switchboard to use Bi-monthly meetings with switchboard Bi-monthly meetings with Barndoc Escalation process in place means that staff have access to on-call manager There has been communication and training with NHS 111	New referral form -go-live which states that referrals received after 4pm will not be actions until the next day Mobile working could enable identification of patient is known to other CLCH services already Query interoperability allowing CLCH to view EMIS	Incidents reported Minutes of meeting with Switchboard and Barndoc Resilience on-call process Copy of new referral form	
1568	Locum cover in place for Service by a GP who does not have level of qualification required to deliver full role as GPwSI dermatology.	6	Possible	Negligible	3	2	09/03/2016	31/07/2017	Prevost, Audrey	Clinical	Business Continuity	Inner Division	Specialist Nursing	Dermatology	Consultant Dermatology locum within GPwSi providing supervision to GP. Reduce number of sessions for GP down to 4 per week as of 28/3/16	Appropriately qualified Gp for the GPswSI post to fulfil the service contract.	Actively pursuing recruitment of GPwSi dermatologist locum to replace the 4 sessions. GPwSi identified via agency. CVs have been sent to Clinical Director to confirm suitable.	
1591	There is a risk to achieving safe staffing levels in all 5 WiCs and UCCs and as a result delivering the contracted service specifications and achieving the contracted KPI performance. This is as a result of: 1. Inability of Temporary staffing to supply temporary staff to fill gaps in the staffing rotas 2. Difficulty recruiting staff to vacant nursing posts	15	Likely	Moderate	12	4	08/04/2016	30/06/2017	Cuff, Andrea	Clinical	Staffing Levels	North Division	Walk In Centres / Urgent Care Centres		1. Trust Roster Management system in place and clear to all staff 2. contingency plan in place for occasions when clinical demand outstrip staffing availability	1. Temporary staffing Team unable to fill vacant shifts with suitably qualified staff	No incident reports for the lack of staff to meet safe staffing levels	

	3. Increase demand for some services, above that previously routinely managed															
1593	There is a clinical risk to patients due to growing antimicrobial resistance and a reputational risk to CLCH due to non-compliance with the following regulations and NHS initiatives: 1.CQC requirements Regulation 12 2.Trust Development Authority (NHS Improvement)3.DH UK 5 year Antimicrobial Resistance Strategy 2013-2018 3.DH Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI). Antimicrobial Stewardship: Start smart – then focus. 4. NICE Guideline: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. Aug 2015 5.Public Health England/NHS England Patient Safety Alert:	12	Possible	Major	12	4	12/04/2016	31/05/2017	Sheth, Anita	Clinical	Medicines Management	Corporate Services		Medicines Management Team	Infection Prevention training in place to help reduce AMR e.g. hand hygiene Clinical pharmacy service at each bedded service which involves screening of prescriptions for clinical appropriateness Annual review of medicines stock lists at clinical settings as part of the Safe and Secure Handling of Medicines Audits Quarterly review of medicines stock lists at bedded services Draft Antimicrobial Stewardship action plan based on NICE guidance CLCH Antimicrobial guidelines in place and updated by MM every 3 years Currently antimicrobial stewardship would be discussed at Medicines Management Group (MMG)	Antimicrobial stewardship action plan to be finalised Specific training on antimicrobials and preventing resistance for all clinical staff currently not provided No retrospective monitoring of antimicrobial consumption throughout the Trust to enable formal reporting to commissioners, NHS England and benchmarking against other Trusts No antimicrobial stewardship group in place within CLCH No antimicrobial pharmacist in place to take forward this work. Benchmarking exercises confirm acute and community trusts have dedicated roles for antimicrobial stewardship No formal access to a microbiologist for CLCH. Currently support is good will from Acute Trusts therefore lack of real accountability and responsibilities	Annual antimicrobial prescribing audit conducted by MM team Monthly IPa and MM update in Medical Director and Chief Nurse report for Quality Committee IP and MM Training uptake Previously discussed at ELT (add dates)	Annual antimicrobial is a snapshot audit of a 2 week period and only covers bedded services. All other services within CLCH that use antimicrobials need to have monitoring of antimicrobial usage.

	Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme Aug 2015 6. The Hygiene Code																	
1594	There is no tier 3 specialist podiatry service in Hammersmith & Fulham locality. If patients present under tier 2 community podiatry, we would not have the option to step up to tier 3 (where there is appropriate level of care) then patients could come to harm.	12	Possible	Major	12	4	14/04/2016	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Podiatry	There has been communication with the CCG via the Diabetes CBU manager There is one clinical lead to support the community podiatrists Management of the diabetic foot SOP is in place Monthly Podiatry team meeting	Clinical lead to peer review the band 7 team leads (H&F) CLCH need to deliver Tier 3 service which has been commissioned by CCG. Weekly virtual clinic to be set up to support community podiatrists	Copy of Diabetic foot ulcer SOP Minutes from Podiatry Team meeting	

1595	If there is no agreed pathway with all stakeholders 'Merton' to step up patients to Tier 4 then then could be a delay in treatment to patients.	12	Possible	Major	12	4	14/04/2016	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Podiatry	New referrals have been 'stepped up' to Tier 4 Diabetic High Risk Patients SOP in place Weekly Team Meetings Caseloads have now been set up on RIO Communication with CCG around pathway All 3 caseloads have been cleansed	Referral pathway for Merton needs to be agreed and SOP updated	Copy of the SOP List of new referrals which have been stepped up Copy of team meeting minutes	A documented referral pathway for Merton Confirmation of cleansed caseload
1604	If there is no formal clinical leadership in the Inner London sexual health service, then there is a risk that doctors are not appraised on their clinical practice which could impact service delivery	9	Possible	Moderate	9	3	25/04/2016	04/04/2017	Mbogo, Mark	Clinical	Service Delivery	South Division	Specialist Nursing and Sexual Health	Sexual Health Services	There is a clinical doctor who is providing informal leadership Clinical practice discussed in team meetings All incidents are reviewed by the clinical doctor All clinicians have now had appraisals and assessments SOP's outlining clinical procedures to be developed	None currently identified	Minutes of team meeting	Copy of the SOP Formal clinical lead in post All staff to have pdp's in place
1611	If recruitment is not undertaken in a timely and effective way and identified vacancies filled, then quality of patient care is at risk due to reduced capacity. In addition, wellbeing of current staff, financial management and planned agency spend targets may be adversely impacted.	12	Unlikely	Major	8	4	27/04/2016	06/06/2017	Davies, William	Clinical	Staffing Levels	South Division		Human Resources	Vacancies have been identified and recruitment started as described in the Merton recruitment plan Regular communication between recruitment team and CBU managers to ensure oversight of activity Discussed weekly at the Agency Review meeting Discussed at the Divisional Board and Divisional Workforce Meeting Process in place for daily prioritisation of patients Reviewed through Trust wide Recruitment and Retention Summit and supported through monthly QAT meeting for West Merton Budgets by for 16/17 finalised to ensure vacancies are clear and agreed Clear overview and feedback from temporary staffing team on cover, requested shifts, and linking shifts to ensure agency spend is reported accurately. For community nursing: matched activity across the	Ensure liaison and communication between recruiting managers, recruitment, and applicants is coordinated and timely to ensure effectively move through pre-employment check process and minimal delays in confirming start dates and correct work locations	Monthly workforce reports for review Monthly finance performance reports Workforce KPI's Notes of monthly divisional Board and south performance review meeting Weekly monitoring of complaints and incidents	Survey staff regularly to check moral

															service to staff numbers and reallocating appropriately to match demand and risk - especially taking into account current issues and shortages of staff in Raynes Park area.			
1612	There is a risk to patient safety and Trust reputation following the identification that CLCH is currently only partially compliant with the Hygiene Code. This is because of the following issues: 1. Changes to the Hygiene Code in 2015 to include specific compliance criteria for antimicrobial stewardship and the requirement for a trust water safety group. 2. Acquisition of new adult and children's community services requiring completion of baseline Hygiene Code assessments.	12	Likely	Moderate	12	6	28/04/2016	27/04/2017	Johnstone, Clare	Clinical	Infection Prevention	Corporate Services	Corporate Services	Infection Prevention	Water Safety Group Water Safety and Quality Policy Antimicrobial Prescribing Guidelines Medicines Management Group Infection Prevention and Control work and audit programme 2016-17	Antimicrobial Stewardship Group Antimicrobial Stewardship Programme Water Safety Plan Required resource to deliver the IP&C work and audit programme	Water safety compliance reports from landlords are received at the Water Safety Group and Infection Prevention Group on a quarterly and annual basis. The Water Safety Group produces a report to assure compliance with water safety in all premises CLCH staff and patients accommodate Completion of baseline audits, to include: waste disposal, sharps disposal, decontamination of equipment Completion of clinical practice assessments, to include: ANTT, hand hygiene and management of MDROs All staff from new services joining CLCH complete or attend infection prevention induction training within first three months of go-live date Production and implementation of a robust Water Safety Plan Audit of antimicrobial prescribing and implementation of identified actions Formation of a multidisciplinary working group to monitor AMS actions	No reports received currently No reports currently received Audits to be completed Audits to be completed Training not completed No Water Safety Plan Audit to be completed AMS Group to be formed
1623	If a consistent approach is not ensured for all electronic clinical record documentation systems (e.g. Kodak/ Blythe/ RIO/ SystmOne), then this may result in limiting access to up to date patient information, breaching professional documentation standards, impacting staff productivity and reducing accuracy of patient activity.	12	Possible	Moderate	9	3	11/05/2016	24/04/2017	Benson, James	Clinical	Data Quality	South Division		IMT	All electronic clinical documentation issues are escalated to IT Service desk Discussed at weekly DMT Monthly performance Board Contract monitoring meeting with CLCH/ Capita All new tenders actively deliver information reporting on a weekly and monthly basis as per contract as by BIPA Rio has weekly reporting	Weekly reporting on performance by BIPA to CBU managers on contractual performance	Monthly performance reports Datix incidents	Weekly performance reports

1635	If the patients who have been referred to respiratory nursing since April 2016 have not been seen their health may deteriorate.	9	Unlikely	Moderate	6	3	23/05/2016	06/06/2017	Mbogo, Mark	Clinical	Clinical Treatment	South Division	Specialist Nursing and Sexual Health	Respiratory / COPD	Clinical team have reviewed the caseload to identify high risk patients The team (including physios and HCA) are seeing patients to assess needs Daily update from service to CBU manager Discussions at DMT & Divisional Board Additional nursing resource has been identified to increase capacity	All patients identified to be offered a telephone assessment Caseload to be cleansed to ensure up to date list is maintained	Minutes of DMT & Board meetings Email copy of daily update to CBU manager (see attached document) Evidence of patients contacted and appointments booked Decrease in patients waiting to be seen	Decrease in patients waiting to be seen
1637	The Trust experiences difficulties in maintaining safe service to patients whilst adhering to the new agency rules including the cap on agency spending. Failing to abide by the rules and abide by the cap results in risks to our transformation funding and our external reputation with NHSI	12	Likely	Moderate	12	4	24/05/2016	01/05/2017	Boynton, Emily	Clinical	Staffing Levels	Corporate Services			Weekly EECG meetings lead by Executive Directors to review all breaches before NHSI submission Regular agency control group with divisions, ADQs, finance and HR input to discuss progress against the spending caps and areas of challenge Introduction of Allocate system allows clear view of usage, cost. location, authorising manager and where breaches are occurring Reporting on the extent of retrospective booking introduced to encourage more accurate forecasting and roster planning Divisions discussing agency use at management forums and CBU managers monitoring performance Provision for exceptions for above cap/non framework use where there is a clinical risk to be considered at EECG Weekly email from Deputy Chief Nurse confirming which agencies should and should not be used	The rates included in the allocate system are subject to variation by agencies and need to be kept up to date to support accurate forecasting The recruitment team need to ensure areas of high agency use are triangulated with effective recruitment campaigns for bank or permanent staff to reduce the demand for agency Agency staff are booked by managers who may not understand our processes and the need for the controls	The level of agency spend against cap is reported to FRIC, NHSI and the Board Progress in respect of good practice against the NHSI toolkit on improving performance in respect of agency and bank is reported to the workforce committee Audit planned for 16/17 in relation to agency use in particular if any use if coded elsewhere to ensure we capture all spend Weekly submission to NHSI of any breaches in respect of price, wage or framework use Services encouraged to report unsafe staffing levels on Datix and reasons for breaches are discussed at the agency control group and EECG Reducing expenditure on agency is part of the QIPP programme for 2016/7 and is supported by the Transformation team Through the STP information on bank and agency use is being shared with a view to coordinating approaches to maximum effect, e.g. working towards consistent bank pay rates	

1643	There is only 1 member of staff in the continence team in Merton. If there is no cover for sickness and absence in the continence service there could be a delay in providing training, approving pads and seeing patients.	6	Unlikely	Minor	4	2	01/06/2016	06/06/2017	Mbogo, Mark	Clinical	Clinical Treatment	South Division	Specialist Nursing and Sexual Health	Continence Care	DN team leaders have been given training and access to the pad ordering service Nurses have been trained to provide general continence advice Job description has been re-worked to include urology to attract new applicants. (it has been advertised twice previously) Recruitment of 2nd member of staff	Full training of 2nd member of staff	Training records	Copy of new job description
1648	Lack of clinical and operational leadership in the Merton community podiatry service could lead to patient harm and low staff morale.	9	Possible	Moderate	9	3	03/06/2016	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Podiatry	Ongoing management of caseload through centralised reports Fortnightly improvement meetings Interim for pathway clarified with team for high risk patients Diabetes and vascular SOP in place Monthly team meetings Interim diabetes clinical lead to support the service until March 2017 Weekly meetings with SPA, re transformation 2 x's acting band 7 in post	Permanent high risk foot pathway to be agreed. Recruitment for team lead and operation lead	Audit of SOP Minutes of team meeting Centralised reports of caseload management	
1689	If System One (S1) is not installed at Pembridge Unit then the timeliness for obtaining test results, medication transcribing errors and inability to easily obtain medical history could occur leading to harm.	12	Likely	Moderate	12	3	06/07/2016	31/03/2017	Jones, Ian	Clinical	Clinical Treatment	Inner Division	24 Hour Services	Pembridge Community	1. Doctor allocated to chase missing clinical information 2. Specialist pharmacist to chase missing prescription information 3. Doctor allocated to chase missing test results 4. Telephone, email and letters to GPs, Community and Hospital colleagues to share information	1. System one	1. All incidents reported on DATIX 2. Governance Meeting 3. MDT and ward meeting	1. None

1694	There is a risk that with the current caseload management including skills, knowledge and staffing levels of staff that patient care will be compromised.	20	Likely	Moderate	12	4	08/07/2016	12/06/2017	Allain, Jackie	Clinical	Service Delivery	North Division	Harrow Nursing, Intermediate Care and Podiatry	Peer Group 5-6 – Community Nursing	Trust policies, pressure ulcer, incident reporting, service specification, stat/man training, appraisals, team meetings separate meetings for each band, safe guarding and infection control training	Lack of understanding of service specification and requirements across all teams. Lack of clarity with leadership role at band 8a and 7 level therefore impacting on cascade to other levels. Gaps in knowledge and skills of varying bands of staff, both Stat/Man training and extended scope. Vacancies at Band 5 and 6 Level, in addition gaps in knowledge and skills required.	monitor and ensure lessons learnt are fed back to team with actions for improvement.	
1697	On review of 298 employee immunisation records following TUPE, the compliance for measles and varicella is poor. Measles 51% and Varicella 58% against CLCH standard of 95% for each. Poor compliance for measles and varicella puts vulnerable patients and staff at risk. The work involved in updating the work immunisation programme of non-compliant staff will have an impact on the rest of the activities within Employee Health service and affect other KPI's.	12	Likely	Moderate	12	6	12/07/2016	27/04/2017	Donnelly, Dympna	Clinical	Infection Prevention	Corporate Services	Corporate Services	Occupational Health	Action plan in place to address the issue. All non-compliant staff emailed regarding outstanding immunisation on 12th & 12th July. Two dates for onsite immunisation clinics arranged for 19th & 25th July at Wilson Hospital and 120 The Broadway Wimbledon.		KPI's for measles and varicella reported at the quarterly infection prevention committee meetings and at the 6 weekly Health & Safety Committee meetings	

1701	On review of 97 employee immunisation records following TUPE, the compliance for measles and varicella is poor. Measles 56% and Varicella 62% against CLCH standard of 95% for each. Poor compliance for measles and varicella puts vulnerable patients and staff at risk. The work involved in updating the work immunisation programme of non-compliant staff will have an impact on the rest of the activities within Employee Health service and affect other KPI's.	12	Likely	Moderate	12	6	14/07/2016	27/04/2017	Donnelly, Dympna	Clinical	Infection Prevention	Corporate Services	Corporate Services	Occupational Health	Liaise with the CBU manager to schedule visits to Harrow sites. Once dates are arranged, email each individual member of staff regarding their compliance and invite them to attend one of the arranged dates for an immunisation update.		KPI's for measles and varicella reported at the quarterly infection prevention committee meetings and at the 6 weekly Health & Safety Committee meetings	
1702	Changes in the recruitment process and the cessation of the sign in sessions twice per month (end February 2016) have contributed to a fall in measles and varicella vaccination for new staff from 95-97% over the last 2.5 years to 93-94% (against a standard of 95%). This reduction puts vulnerable patients and staff at risk. Furthermore, the capacity requirements associated with updating the immunisation of non-compliant staff may negatively impact other Employee Health activities and KPI's.	12	Likely	Moderate	12	6	14/07/2016	27/04/2017	Donnelly, Dympna	Clinical	Infection Prevention	Corporate Services	Corporate Services	Occupational Health	Action Plan - Met with the Recruitment Director (Capita) - Sharon Kaur 7th July to discuss the recruitment process. Revert to the original process for the new staff acceptance forms which had been in place since 2010 for bank and permanent staff until the TRAC process is up and running. Sharon to take the bank lists back to her team for cleansing. Once this data cleansing is completed, resend the updated list to Employee health who will produce a compliance list. Those bank staff who are non-compliant for immunisation will be contacted by the recruitment team and advised that they will be unable to have a work assignment until they attend EH for screening, amnesty one month. Existing permanent staff will be contacted by EH and asked to attend for screening, if they do not respond, manager to be emailed.		KPI's for measles and varicella reported at the quarterly infection prevention committee meetings and at the 6 weekly Health & Safety Committee meetings	

1703	Poor attendance at training has resulted in training having to be cancelled and consequently loss of funding. There is a potential risk that staff are not appropriately trained/developed to deliver services effectively and funding wasted.	8	Likely	Minor	8	6	14/07/2016	28/02/2017	Stevenson, Tracy	Clinical	Clinical Treatment	Corporate Services			training and study leave policy states that non-attendance will be charged Standards outlined by Professional Bodies e.g. NMC, HCPC	charges for non-attendance only applies to statutory mandatory training multiple training directed at same staff group on same day	audit of course non-attendance and rationale	
1707	Lack of a robust infrastructure and leadership within the district nursing teams could lead to serious issues which may not be managed in line with guidance, best practice and within required timescales. This could adversely affected quality of care, service delivery and staff wellbeing.	20	Unlikely	Moderate	6	2	20/07/2016	25/04/2017	Danks, Alison	Clinical	Service Delivery	South Division	West Locality (Merton)		Fortnightly meeting with senior nurses to discuss issues Clear escalation plans are agreed weekly and disseminated Staff are attending band 6 leadership development programme All 8a posts recruited to	None currently identified	Minutes of team meetings where issues are discussed Monitoring number of incidents	
1708	Between 7am-8am & 5pm-6.30pm there is currently no formalised clinical community nursing provision for patients. This could lead to urgent calls for high risk patients not being dealt with in a timely manner.	6	Possible	Minor	6	2	20/07/2016	06/06/2017	Danks, Alison	Clinical	Clinical Treatment	South Division	East Locality (Merton)		All out of hours calls come through to SPA Staff are informally covering shifts ('gaps') and are paid overtime for it Working party has been set up New starters working to new 24 hour patterns	Formal consultation on shift covers to ensure it covers 24hrs	No complaints/ incidents received	
1709	There is a risk that district nursing visits might be missed or delayed which could lead to patient harm.	12	Possible	Major	12	4	20/07/2016	06/06/2017	Read, Julie	Clinical	Clinical Treatment	South Division	West Locality (Merton)		Admin currently list the patients who have been seen (according to tee-cards) Pilot has been initiated to look at allocated patients to add them straight to RIO the day before the visits are due Staff are aware of the importance of reporting 'missed visit' incidents on Datix Staff are now using the RiO team planners	Review of all missed visits to look for the root causes Review of the 'Tee-card' system Review of Rio to ensure no visits are missed	Number of incidents/ complaints received	Review of pilot

1716	There is currently up to high vacancy rate for Band 5 Community Nursing teams. This increases the risk of staff being unable to cover all patient visits. This also impacts workforce fatigue & sickness due to increased hours worked by substantive staff, and impacts staffing being able to attend mandatory training.	12	Possible	Moderate	9	3	08/08/2016	09/05/2017	Read, Julie	Clinical	Clinical Treatment	South Division	West Locality (Merton)		Temporary staffing, bank and agency and overtime are all covering shifts Rolling recruitment campaigns Recruitment incentive campaign Regular engagement with recruitment team Review of pre-employment check process completed Monthly meeting with recruitment team to discuss issues is now in place	Recruit to all permanent posts		
1717	There is currently only 1 permanent Domiciliary Therapies Service Occupational Therapy staff in post in Merton (out of 5 posts), this could lead to a reduced robust provision related to 1 staff member only and patients having to be referred to other services within CLCH and could delay patient treatment.	6	Unlikely	Moderate	6	3	08/08/2016	05/06/2017	Read, Julie	Clinical	Clinical Treatment	South Division	West Locality (Merton)	Domiciliary Therapies	Patients are being see by Physiotherapists instead of O.T's Some patients are seen within Rapid Care services Ongoing recruitment campaigns including recruitment incentive	Recruitment of 3 O.T posts		
1720	Clinical Risk caused by Staffing issues (Mat Leave cover by other services means reduced staffing in the LAC Inners and Barnet Teams)	15	Unlikely	Moderate	6	6	08/08/2016	03/04/2017	Adamah, Audrey	Clinical	Staffing Levels	Children's Division	0-19 Service Westminster and Kensington & Chelsea	Looked After Children's Team				

1743	Insufficient assurance on the actions required for Patient Safety Alert NHS/PSA/RE/2015/008 Stage Two: Resources Supporting the introduction of the National Safety Standards for Invasive Procedures	9	Possible	Moderate	9	3	14/09/2016	27/07/2017	Gata-Aura, Roveena	Clinical	Clinical Treatment	Corporate Services	Corporate Services					Identifying services affected by alert
1757	Due to unplanned and sudden loss of IT connectivity, there is a probability that patient information will not be fully captured, causing the possibility of patient harm e.g. missing allergy information and also not able to provide the appropriate tests and treatment; and necessitating the recall of patients and any known contact tracing. There is also a potential for Financial loss and reputational damage due to current partial temporary and permanent disruption of the Blithe Lilie Sexual Health EPR system, in Hertfordshire.	12	Unlikely	Moderate	6	6	11/10/2016	28/04/2017	Pickett, John	Clinical	Service Delivery	North Division	Sexual Health	Sexual Health Services	Down time procedures Within scope of Clinical Applications therefore support from IT		Downtime procedure would be in force, which would mean manual collection of Commissioner KPI's	

1766	CLCH became responsible for the care of intermediate care patients in Merton on 1st October. The nursing care, estates and facilities will be subcontracted to Cecil and Central Housing subject to contracts being signed. The homes are Woodlands House (17) beds and Carter House (7) beds. The Governance arrangements have therefore changed but have not been clarified. The effect of this change is that as CLCH do not manage the nursing staff, there is a lack of assurance that standards of care meet the expectations of CLCH. The impact is that patients may not receive the nursing care and treatment required.	16	Possible	Major	12	4	14/10/2016	30/04/2017	Waskett, Rosie	Clinical	Clinical Treatment	South Division	Integrated Care (Merton)	Inpatient Rehabilitation (Merton)	Staff have been given the CLCH mandatory training handbook Quality Action Team is in place and meets weekly Meetings set up with Cecil & Central clinical lead to discuss gaps in expectations in standards of care Weekly MDT meeting with CLCH nursing, therapy and clinical director at both homes to discuss any issues Expectations of recording observations have been explained to staff, and a new observation chart has been introduced The deteriorating patient policy has been shared with the staff	The subcontract for 6 months with Central and Cecil will include the provision of nursing staff The subcontract for the 6 months starting on 1st April 2017 has been sent to C&C but no feedback has been received to date. An outstanding item from the contract review is the governance and escalation process within Woodlands	KPI's report on mandatory training Information document to Quality Committee QAT action plan QAT action plan is shared with commissioners Issues log shared with Cecil & Central	Audit of observation chart Escalation of deteriorating patient's
1767	Risk to out of area children attending the WiC/UCC as comprehensive child protection information is lacking for these out of area patients.	6	Possible	Minor	6	2	14/10/2016	31/05/2017	Cuff, Andrea	Clinical	Safeguarding - Children	North Division	Walk In Centres / Urgent Care Centres		Age range for accepting children will not be lowered until assurance re processes in place Current safeguarding processes being followed			

1768	There is a risk to the delivery of a high quality service to patients at the Parsons Green WiC as there is insufficient clinical room capacity to meet the rising daily demand for services.	8	Likely	Minor	8	4	14/10/2016	30/06/2017	Cuff, Andrea	Clinical	Estates and Site Management	North Division	Walk In Centres / Urgent Care Centres	Parsons Green Walk in Centre	Secure ad hoc additional clinical room when freed up by other services Manage demand in line with escalation policy Monitor demand on daily basis		Reviewed monthly at North Divisional Board	
1769	An audit has identified inconsistent practice in relation to child protection, safeguarding and general HV caseload management (15 cases audited) and they appear not to have been managed in accordance with CLCH safeguarding, clinical practice guidelines and therefore there is a potential risk of vulnerable children and families not receiving appropriate care and therefore increased risk of harm.	12	Possible	Moderate	9	3	19/10/2016	01/04/2017	Heffernan, Shelley	Clinical	Safeguarding - Children	Children's Division	Merton Children's Services	Health Visiting	1-1 safeguarding caseload review Weekly management and Safeguarding meetings CLCH Safeguarding policies and guidance Safeguarding supervision PAN London Safeguarding policy Safeguarding level 3 training for all clinicians Working together to Safeguard Children 2015 - national guidance	Review of current Safeguarding caseload Review of Safeguarding supervision policy Review of caseload supervision processes in Merton Development of pre supervision template Implementation of the London Continuum of need Foster a culture of ongoing caseload review and management	Weekly meeting summaries by management and safeguarding teams Action plans from weekly meetings Local policies have been approved by Policy ratification group Quarterly reports for Safeguarding supervision Quarterly reporting for Safeguarding training	Review in monthly Quality and performance review meetings Review in Safeguarding committee
1772	Risk to Harrow Cardiology Service providing a full diagnostic service as equipment for Cardiology diagnostics is currently on temporary loan which is due to expire.	9	Possible	Moderate	9	2	21/10/2016	28/04/2017	Laffey, Patrick	Clinical	Business Continuity	North Division	Long Term Conditions (Barnet, Harrow and Herts)	Heart Nursing Service	A list of all equipment on loan has been generated and a request to purchase the equipment has been submitted together with a request for the proposed purchase price	Lack of clarity in terms of responsibility for the current servicing of equipment		

1779	Risk to Patient safety due to lack of working landline telephones	15	Unlikely	Moderate	6	3	03/11/2016	28/04/2017	Cupid, Wendy	Clinical	Business Continuity	North Division	Community Nursing Services - Barnet	North Locality - East Barnet	Contingency plan for business as usual i.e. mobile 'phones/diverting calls to a different number	Use mobile telephones as alternative - poor mobile signal at Holbrook House diversion to another number - calls taking longer due to increase in number of calls through diverting	Restoration of service to business as usual by the installation of working landline telephones	
1781	There is a patient safety risk (i.e. items being used clinically after the expired servicing date) and financial risk (i.e. items potentially missing/lost) associated with medical devices that are not being presented on time for servicing.	12	Likely	Moderate	12	6	11/11/2016	28/04/2017	Johnstone, Clare	Clinical	Medical Devices	Corporate Services			Equipment asset database (HEMS) on intranet BCAS servicing contract BCAS Contract Meetings (monthly) Medical Devices Policy Medical Devices & Product Selection Group (MDPSG) List of equipment which has not been serviced in the last 12 months		BCAS Servicing Contract KPIs reports	
1782	Unsuccessful recruitment (advertised and interviewed 5 times) to Paediatric community physio therapy post in Merton, has resulted in some children not being assessed within an appropriate time frame and therefore not receiving timely treatment. MSK physio cover for annual leave has been unsuccessful so there is no cover for the service for 2 weeks.	12	Possible	Moderate	9	6	11/11/2016	05/05/2017	Gladwell, Ruth	Clinical	Staffing Levels	Children's Division	Merton Children's Services	Physiotherapy	Physio therapist providing 1 day a week Prioritisation of waiting list - 5 day and 20 days response criteria Physio therapy assistant to support delivering treatment Collating service user feedback EHCP plans are being prioritised and managed Responding to pals/ complaints and logging informal complaints Reviewing Team leader structure liaised with professional Lead for AHP		Review recruitment and retention Report back to the commissioners operational group monthly - KPI dashboards Dashboard at performance review Review of waiting lists and Perseid caseload plan devised and monitored via divisional board	

1786	If there are inadequately trained nursing and health care assistant staff employed by C&C Housing at Woodlands House and Carter House then this may result in staff not following resuscitation protocols. Patients requiring resuscitation would risk resuscitation not being attempted. The impact on the patient could be catastrophic and lead to unnecessary death.	20	Unlikely	Catastrophic	10	5	31/10/2016	07/03/2017	Waskett, Rosie	Clinical	Clinical Treatment	South Division	Integrated Care (Merton)	Inpatient Rehabilitation (Merton)	All staff have received basis training and use of defibrillator Agreement in principle for C&C nursing staff to TUPE to CLCH therapy staff are CLCH and training in resuscitation should this be required in working hours Assessment of current training status on C&C nurses complete CLCH policies in place relating to resuscitation	Sub contract to be agreed by ELT to include nursing provision Learning needs assessment and training programme to be conducted once staff identified	Training records	Lack of assurance that C&C staff would attempt resuscitation out of hours
1802	If Merton District Nursing staff do not maintain a consistent approach to record keeping, in adhering to NMC standards and CLCH policy (RiO being the main record) then there is a risk to patients safety.	9	Possible	Moderate	9	3	01/02/2017	09/05/2017	Danks, Alison	Clinical	Documentation	South Division	East Locality (Merton)		Record keeping policy in place and shared with all nurses NMC guidelines have been shared with all nurses Record keeping is a regular agenda item on the team and senior meetings All staff have been provided with laptops Standing agenda item on team meetings	Vacancies to be recruited to	Record keeping audit	Local RiO audit to be undertaken Regular spot-checks
1803	When the Blithe Lillie EPR system is updated to version 7.2 on 8th March, there will be a potential lack of accessibility and loss of patient information, causing major disruption to the continuity of service provision and damage to the reputation of the trust.	12	Possible	Moderate	9	6	07/02/2017	28/04/2017	Pickett, John	Clinical	IT Systems	North Division	Sexual Health	Sexual Health Services	Project plan for the implementation of the updated version of Blithe Lillie		Reduced incidents and less disruption to services Timely reporting of the agreed dataset and KPI's to LA Commissioner	

1805	Building works at Southgate Clinic are currently due to finish at the end of March/beginning of April and the services are due to be vacating Kingsway for Southgate Clinic on 12th and 13th April for the service to recommence on the 18th April. If the building works are delayed this will have a major impact on the vacation of the Kingsway Clinic causing major disruption to services.	6	Unlikely	Moderate	6	2	07/02/2017	28/04/2017	McCann, Una	Clinical	Estates and Site Management	North Division	Sexual Health	Sexual Health Services	Building works plan running according to schedule	Contingency plan for vacating Kingsway at the end of the lease (mid-April) if building works at Southgate not finished on time (end March/beginning of April)	Estates monitoring of the building works plan and reporting back to Project Manager (JP)	
1806	If Pembridge does not secure locum consultant for on-call rota (which it shares with St Johns Hospice), the service will not have adequate medical cover and may need to close beds Pembridge has a consultant on long-term sick and another leaving mid-March. St John's has a consultant going on mat leave in March and another leaving in March	12	Likely	Moderate	12	3	10/02/2017	30/06/2017	Jones, Ian	Clinical	Business Continuity	Inner Division	24 Hour Services	Pembridge Beds and Day care	Meetings set up with Director at St Johns to review recruitment / locum progress Internal meetings with Lead Nurse and Consultant Medical Director informed Capita / Temp staffing prioritising Flexing junior doctors rotas Proactively contacting acute hospitals and other hospices		Regular monitoring of recruitment status BCP may need to be put in place and patients decanted to other units Minimum staffing levels / rotas regularly reviewed	Minimum medical staffing policy not in place
1807	A recent CD medicines audit has highlighted a lack of full compliance with the CD medicines management policy, this may result in a reduced quality of patient care.	12	Likely	Moderate	12	2	10/02/2017	28/04/2017	Ali, Sulekha	Clinical	Medicines Management	North Division	Inpatient Rehabilitation (Barnet and Harrow)	Inpatient Rehabilitation (Jade Ward)	Trust Medicines Management Policy in place NMC standards for medicines management Service level instruction about CD audit action plan by Matron Service level SOP for hand over in relation to administration of medicines by Matron	Staff's understanding of service level SOP, NMC and trust medicines management policy	Review of medicines management audit (CD audit) Reduction of incidences reported in relation to CD Spot checking by Matron	

1809	Alert expired on 17 February 2017 and approval from NICE Group is required on actions completed, to demonstrate compliance of alert: NHS/PSA/RE/2016/007- Resources to support the care of patients with acute kidney injury, before the alert can be closed.	9	Possible	Moderate	9	3	16/02/2017	31/05/2017	Medhurst, Dr Joanne	Clinical	Clinical Treatment	Corporate Services						
1813	Oxygen is now a requirement for all clinics in which intrauterine instrumentation is being performed, according to the new guidelines published by the Faculty of Sexual and Reproductive Health in August 2016. Barnet Sexual Health services do not have oxygen in the clinics where IUD's are fitted, meaning there could be a risk to patient safety should there be an incident.	6	Unlikely	Moderate	6	3	23/02/2017	02/05/2017	Pillai, Sarah	Clinical	Medication - not involving Controlled Drugs	South Division	Specialist Nursing and Sexual Health	Sexual Health Services	Faculty of Sexual and Reproductive Health in August 2016 There is oxygen in the building, but not easily accessibly at all sites except Graham Park Twice weekly team meetings to discuss issues Quotes for oxygen have been received	Decision as to whether oxygen will be purchased	Minutes of team meetings	
1818	The lack of a functioning eFax machine at Woodlands House, intermediate care facility may lead to delay in adjusting anti-coagulation medication for a patient following blood clotting analysis. This could lead to too little or too much anti-coagulation medication with the risk to the patient of bleeding or thrombosis.	9	Unlikely	Moderate	6	3	27/02/2017	06/06/2017	Willis, Patricia	Clinical	Clinical Treatment	South Division	Integrated Care (Merton)	Inpatient Rehabilitation (Merton)	Stand alone printer has been installed to support the ability of the CLCH therapy staff to receive information securely and upload the document to RiO and allow a printed copy to be added to the patients nursing record Woodlands House QAT in place, where this is discussed MDT meetings & Contract review meetings Clinical discussions in ward rounds	CLCH have no control over the C&C IT System Woodlands House nursing staff are not employed by CLCH	Incidents are reported on Datix which will identify and facilitate appropriate action to be taken QAT action plan Results of pharmacists ad hoc nursing transcribing practice	None currently identified

1822	If the current backlog of 1 year development reviews across Barnet health visiting service is not cleared in a timely manner there is a clinical risk to the children and a reputational and financial risk in relation to the commissioners and contract performance.	6	Likely	Moderate	12	6	10/03/2017	28/04/2017	Cody, Angela	Clinical	Clinical Treatment	Children's Division	0-19 Services Barnet, Brent, Harrow and FNP Barnet	Health Visiting	Healthy Child Programme in place setting out requirements for HR1 reviews Training Programme for Child & Family Health Advisors with competency assessment available Job plans in place for Team Leaders setting out responsibilities and CBU Manager expectations Action Plan with timescales in place for each team	Capacity has slowed down the ability to clear the backlog by end March 2017	Monitored monthly at the CBU Integrated Quality & Performance Review.	None identified
1834	Increased risk of harm to patients and negative affect on business continuity as a result of reduction in establishment of nursing staff and decrease in service capacity; which impacts on -ability to meet the Cardiac Heart Disease Key Performance Indicators; -GPs having reduced access to specialist nursing input: -increase in waiting times for cardiac nursing services.	15	Likely	Moderate	12	4	05/04/2017	10/04/2017	Laffey, Patrick	Clinical	Service Delivery	North Division	Long Term Conditions (Barnet, Harrow and Herts)	Heart Nursing Service	Business Continuity Plan e-rostering and filling vacant shifts with temporary staff Flexible use of resources across Heart Function Barnet and Harrow Cardiology Redirection of clinical input to Virtual Ward or rapid response as required	Interim Triage process for referrals to manage risk and prioritisation Short term secondment to Heart nursing team potential further resignation / sickness / annual leave / study days Lack of ability to source bank or agency staff	Patient contacts data Workforce vacancy data	
1835	Due to low staffing levels within the Inner London podiatric surgery service, there is a risk of increased waiting times for patients to be seen and potential for some surgeries to be cancelled.	12	Likely	Moderate	12	3	05/04/2017	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Podiatric Surgery	Consultant from Merton to cover some theatre lists Review of theatre current lists has been undertaken and prioritised Process in place for all future surgery to be assessed on consent Ensuring communication at consent to ensure patient expectations in terms of waiting times are met	Completion of contingency planning Re-establish weekly meeting between all practicing podiatry surgeons To consider putting out a position request on allocate	Review of incidents and PALS	

1836	If we are unable to recruit a dysphagia trained SALT member of staff in the Merton Neuro team then there is a risk that we unable to see any patients with dysphagia needs which could lead to an unnecessary hospital admission. This could also affect waiting times targets.	12	Likely	Moderate	12	3	05/04/2017	02/05/2017	Menger, Beth	Clinical	Clinical Treatment	South Division	Specialist Therapies	Speech and Language Therapy Service - Adult	Joint working with Merton adult SALT to prioritise dysphasia patients over communication patients Working with agency to look for cover	Recruitment of permanent member of staff- interviews to be held on 18th April		
779	There is a risk to patient safety and also a financial risk to services if the cold chain is not maintained, medicines requiring refrigeration, including vaccines may not be effective; may affect service delivery and medicines may need to be destroyed.	12	Unlikely	Major	8	4	20/05/2013	31/05/2017	Butt, Arfana	Clinical	Medicines Management	Corporate Services		Medicines Management Team	Support provided to ensure robust processes in place by pharmacy technicians Cold Chain Policy in place All K&C and Westminster clinics are receiving twice a year visits where cold chain aspects are audited and any issues raised with the clinical leads. 08.02.16 Cold Chain training package developed in June 2015. Nine sessions delivered to date with 144 staff attendance.	Evidence that staff are not following policy resulting in cold chain breaks.	Negative assurance from audits reports taken to MMG in May 13 New Safe and Secure handling of medicines audits, including Cold chain commenced June 2014. To be reported to MMG and CARSG	

684	If Intermediate Care MSK ESP clinicians have not been signed off against the competency framework then patients could come to harm.	12	Unlikely	Moderate	6	4	02/05/2013	28/04/2017	Abdulla, Valerie	Clinical	Operational Risk	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	MSK Physiotherapy	Risk assessment undertaken (see documents) Standard CLCH competence framework is in place There has been an alignment of Royal Free & Barnet Hospital and Barnet MSK communclinics	Review of SLA Staff to have started watched assessments All ESP's to be signed off against competency framework	service user feedback, incidents and complaints, compliments RCA and competency issues fully resolved.	Requires consistent consultant supervision
689	If staff do not maintain a consistent approach to record keeping then there is a risk to patients safety.	15	Possible	Moderate	9	3	22/05/2013	06/06/2017	Menger, Beth	Clinical	Operational Risk	South Division	Specialist Therapies	Podiatry	Working group with Podiatry Steering Group overseeing Daily clinic rota not incorporates 25 minutes before lunch and 55 minutes at the end of the day to ensure that record keeping is complete SystmOne SOP in place Initial appointment slots have been lengthened in time to facilitate SystmOne documentation and time this takes to complete. All clinical staff have been made aware of Health Record Audit results and areas where practice improvements need to be made. Discussions have taken place with all locality podiatry leads and issues have been highlighted, local actions are in process.	New templates to be uploaded to SystmOne Training for new staff on templates	Record keeping audit Minutes and actions from Working Group and Steering group	awaiting service specific results of audit

786	Patients are being discharged from hospital without appropriate discharge planning resulting in re-admission. There is a risk to the patient's health and experience.	15	Possible	Moderate	9	3	19/07/2013	31/05/2017	Molloy, Cora	Clinical	Communication	Inner Division	Community Nursing - Tri Borough		1. All referrals to be made via Single Point of access 2. All Senior Nurses are aware not to accept poor discharge documentation and will contact referring hospital for missing information. 3. As part of the CIS lead provider scoping work. There are current work streams in place that are looking at e.g. communication between CLCH and local acute trusts. This is a step in the right direction for engaging with local acute providers to work together on improving discharge planning	1.Hospitals referrals direct to teams via fax 2.Referrals arriving OOH and no follow up checks by hospital to confirm receipt 3.Incomplete clinical information on referrals 4.No link/liaison between referring hospital and DN team 5.Standard referral form not being completed properly by hospitals 6. Delays in receiving referrals from the SPA team	1. All poor referrals are discussed with Clinical Lead and Service Manager and reported as an Incident on DATIX 2.Standard agenda item on the monthly Senior Nurses Meeting 3. Commissioners have negotiated CQUINs with the local acute trusts related to improving the patient discharge process	There is a need for a discharge champion to be identified by the acute care providers, to work with CLCH on addressing issues relating to poor discharge
Environment																		
1366	Risk to staff safety due to a lack of workplace risk assessment in clinic space within CLCH. (in relation to St Charles Community Clinic 2, Soho Ground floor Room 3, Charring Cross Pilot Wing, Clinic Room 8).	4	Unlikely	Major	8	4	04/08/2015	02/05/2017	Menger, Beth	Environment	Health and Safety Hazards	South Division	Specialist Therapies	Specialist Weight Management Service	Work place risk assessments for all clinic spaces Staff had received training in risk assessment Health and Safety Policy Work place checklist Monitored at the Estates and Facilities meeting Support in completion of risk assessments from Health & Safety team	none currently identified	Minutes of Estates and Facilities meeting	None currently identified
1400	Risk of ceiling collapse as a result of incorrect fittings being used in suspended ceilings.	6	Unlikely	Moderate	6	3	12/10/2015	31/08/2016	Burns, Lesley	Environment	Estates and Site Management	Corporate Services			Process in place whereby assessment of fixtures and fittings for suspended ceilings are to be carried out by the contract lead and project manager on an ‘as needs’ basis.	Our own sites are only being inspected when refurbishment works are underway and prior to completion (no trust wide audit planned) At present the assessment of fixtures and fittings for suspended ceilings is carried out on an ‘as need’ basis and is based on a verbal briefing from RF to TP. Since agreement is not written into ‘New and Refurbished Buildings Policy’ there is a chance that ‘corporate memory loss’ due to turnover of staff would result in an oversight	Minutes taken at project meetings. Minutes record actions involving suspended ceiling activities e.g. fixtures and fitting inspections (it is the responsibility of project manager to update HEF on these issues at each meeting). In HEF’s absence at project meetings, email update sent to operational managers of estates and facilities.	Not all project meetings minuted. Updates are verbal. Where ceiling fixtures are worked on or disturbed, information is not included in a written report.

1426	accessibility issues for wheelchair users. This could lead to sickness and absence of staff, including moving and handling injuries, and Risk to patient and staff safety due to Podiatry clinic room being risk assessed as having poor ventilation, variable temperature and wheelchair users being unable to access the service.	6	Possible	Minor	6	2	22/10/2015	04/07/2017	Menger, Beth	Environment	Health and Safety Hazards	South Division	Specialist Therapies	Podiatry	Contact in estates to make manual changes to room temperature Staff have access to fans and heaters All staff attend manual handling training Health and Safety Risk Assessment has been undertaken on the room All staff to be reminded of process to follow if temperature needs to altered Space request form to be submitted	NHS Property services to look for alternative clinic space to accommodate wheelchair users There is no timeframe for NHS to rectify heating and ventilation issues	Manual handling training records	
1704	There is a possibility that water safety / legionella issues may arise in Trust premises due to a lack of regular and managed testing.	10	Unlikely	Catastrophic	10	5	15/07/2016	20/01/2017	Daccus, Ian	Environment	Estates and Site Management	Corporate Services			Water safety inspections are carried out in accordance with Trust policy and L8 Approved Code of Practice -Control of Legionella Bacteria in Water Systems. Control of Contractors policy ensures works cannot be undertaken without the contractor going through a rigorous approval process. This policy also states that risk assessment and method statements will be submitted for Trust approval in advance of major works taking place. Post project reports are being completed by ISS and NHSPS E&F Managers maintain work activities on site and address accordingly	Lack of full control of all contracts carried out on Trust premises and those owned by NHSPS.	ISS and NHSPS are conducting legionella water safety assessments on behalf of the Trust. The Water Safety Group meetings are scheduled and members review reports submitted by third party contractors. Authorised Persons Water (APW) and Authorised Persons Maintenance (APM) as well as an External Independent Authorising Engineer (EIAE) , Dr Nick Hill have been appointed by ISS	Post project and monitoring reports are not always available for review and audit. No APW, APM or EIAE appointed by NHS PS.

1759	There is a risk that denial of access to a CLCH site, or a site at which CLCH provides services, could cause significant disruption to services. Short-term impact would be similar irrespective of the nature of the incident (e.g. flood, power failure, security cordon etc.) This may result in total or partial evacuation of the building and the damage could take a significant amount of time to rectify. In the example of a flood very often important IT equipment is located in the lowest point of buildings, where they are at the highest risk of water damage. In the example of a power failure there is generally insufficient space for a permanent generator to be on site. This means that some of our business critical services (particularly bedded units) are reliant upon the national grid for power, and in the event of an extended outage we are reliant on landlords and/or estates and facilities staff to provide a generator within a short space of time.	8	Unlikely	Major	8	6	11/10/2016	21/04/2017	Biden, Sam	Environment	Business Continuity	Corporate Services	Corporate Services	Resilience and Compliance Team	1) Flood risk assessments from local authorities/environment agency. 2) Trust Business continuity plan and service business continuity plans. 3) CLCH table top flooding exercise held in 2012 and bedded unit evacuation exercise held in 2016. 4) Infrastructure works at Athlone House and Alexandra rehab units following Garside House power failure in 2013, to allow a leased generator to be installed quickly.	1) BCPs not in place for all services and sites. 2) Due to local geography as a Trust we are not fully aware of risks to each site (e.g. locations of major water mains). 3) Lack of clarity around generator provision for key sites. 4) Unclear if a contract is in place with landlords for urgent generator delivery (as advised following a major power failure incident in 2013). 5) Lack of assurance from landlords around testing of generators where they are in place at major sites.		

1762	There is a risk that in an emergency the Trust cannot rely on landlords to respond in a timely and effective manner to issues relating to the estate. This is a particular concern for power failures out of hours as we have in the past been unable to report issues to UK Power Networks without assurance that the fault is not internal, which we are unable to determine without E&F advice. This can then cause significant delays in response.	12	Possible	Major	12	8	11/10/2016	21/04/2017	Biden, Sam	Environment	Business Continuity	Corporate Services	Corporate Services	Resilience and Compliance Team	1) Backup contact details (direct mobile numbers for staff members) provided by NHSPS and ISS 2) Ability to contact NHSPS centrally in the event of communications issues with local teams. 3) Numerous key CLCH sites have been transferred from NHSPS to ISS as part of the Capita strategic partnership and to date no major concerns have been raised.			
1789	If we are unable to secure sufficient guaranteed parking spaces for staff within close proximity to the Civic Centre, then this could impact staff productivity and service delivery.	10	Possible	Minor	6	2	05/01/2017	06/06/2017	Greenleaf, Dan	Environment	Estates and Site Management	South Division			Sufficient number of permits for road parking Dialog with relevant person at the Civic Centre Merton estate group which meets monthly Staff consultation regarding move	Teams to look into alternative ways of working / change of culture	Minutes of Estates group Email communication between head of performance and Civic Centre Copy of consultation	Staff survey to be sent to staff on how the move went and issues identified
Event																		

1758	There is a risk to the delivery of CLCH's services in the event of a pandemic influenza outbreak. It is the highest rated risk on the national risk register due to its comparatively high likelihood and high impact. The consensus view among experts is that there is a high probability of another influenza pandemic occurring. It is impossible to forecast its timing or the nature of its impact. Impact on CLCH would be similar to other NHS organisations – increased attendances at Walk-in/Urgent Care Centres, higher staff absence rates and knock-on impact of family members being unwell (carer absences).	12	Possible	Major	12	8	11/10/2016	21/04/2017	Biden, Sam	Event	Business Continuity	Corporate Services	Corporate Services	Resilience and Compliance Team	1) CLCH Pandemic Influenza Plan 2) Engaged with Borough Resilience Forums, Public Health England and NHS England around planning and surveillance	1) CLCH Pandemic Influenza plan has not been tested. 2) New national arrangements have not been tested.		
1760	There is a risk of large scale staff absence for various reasons (industrial action, widespread transport failure, pandemic etc.) Whatever the cause, this could have a major impact on patient safety and quality of services. This would be most severe if the cause of the absence is protracted (e.g. pandemic influenza).	8	Unlikely	Major	8	8	11/10/2016	21/04/2017	Biden, Sam	Event	Business Continuity	Corporate Services	Corporate Services	Resilience and Compliance Team	1) Trust business continuity plan and service business continuity plans. 2) Adverse weather conditions and severe travel disruptions policy. 3) Pandemic influenza plan.	1) Service business continuity plans not in place for all areas. 2) Pandemic influenza plan not tested.		

1761	There is a risk that in the event of supply chain failure teams across the Trust will be severely impacted as sites do not typically have stores for supplies and often work on a just in time ordering process.	6	Unlikely	Moderate	6	4	11/10/2016	21/04/2017	Biden, Sam	Event	Business Continuity	Corporate Services	Corporate Services	Resilience and Compliance Team	1) NHS Supply Chain business continuity plan. 2) Service business continuity plans	1) Business continuity plans not in place for all services. 2) Unclear whether Procurement still have the ability to order items from alternative providers in the event of a supply chain failure.		
1764	There is a risk that hazardous materials (hazmat) or Chemical, Biological, Radiological or Nuclear (CBRN) incident could occur within walking distance of a CLCH site, resulting in the possibility that members of the public will self-present, which could cause contamination and harm to patients and staff if not managed correctly.	8	Unlikely	Major	8	8	11/10/2016	21/04/2017	Biden, Sam	Event	Emergency Preparedness	Corporate Services	Corporate Services	Resilience and Compliance Team	1) Training for at risk staff (primarily WiCs/UCC and front of house staff).	1) CLCH Hazmat/CBRN plan has not been finalised or tested. 2) Not all WiC/UCC and front of house staff have received training.		
Finance, Performance, Contracts and Strategy																		

1074	Continued overspending on temporary staffing costs could cause the Trust to fail in achieving its financial plans during a financial year.	12	Possible	Major	12	8	14/02/2014	30/04/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Temporary Staffing Control Group established and Chaired by CEO with Chief Nurse & Director of Quality Governance which reviews performance against divisional agency targets and actions to reduce agency spend EECG has been established under the Medical Director to review controls for commissioning temporary staffing and reviewing breaches in procedures in booking alol temp staff through framework and at cap rates Divisions and CBUs have been issued with monthly targets for maximum agency spend and have weekly or fortnightly internal review meetings to identify issues with performance All bookings of temporary staff must be placed via the temporary staffing office and no payments to agencies can be made without an invoice quoting a valid temporary staffing booking reference		Agency performance is reported monthly via the IFPR to ELT, FRIC and Trust Board Weekly data available for divisions based on projected spend on Allocate and internally	
1165	If funding is not obtained to meet the DoH minimum staffing at Pembridge then we will exceed the budget and over spend.	9	Possible	Moderate	9	1	28/07/2014	31/03/2017	Jones, Ian	Finance, Performance, Contracts and Strategy	Financial Risk	Inner Division	24 Hour Services	Pembridge Beds and Day care	Financial impact analysis to quantify overspend has been undertaken Recruitment plan has been created DH guidance set re: safe staffing levels Agency staff used when staffing levels fall below guidance levels	Recruitment of staff	Daily return to DOH re. staffing level	Disconnect between quality & finance reporting

1193	There is no Trust wide approach to centralising destruction of confidential waste. This may lead to poor management of records and loss of confidential information resulting in a data breach. A data breach may incur monetary penalty from the ICO of up to £500k	12	Unlikely	Major	8	4	15/10/2014	06/01/2017	Daccus, Ian	Finance, Performance, Contracts and Strategy	Estates and Site Management	Corporate Services	Corporate Services	Estates and Site Management	Information Governance training covers importance of records management and destruction 57 Approved Cross cut shredders have been approved by CIG. These are due to be delivered to the 57 major sites by 12 December		Business Case to be submitted to CIG for level 4 security cross cut shredders to be delivered to 57 major sites. CIG approved Business Case on 29/10/14	The current confidential waste collection contracts are not up to date and available to all services. Although 57 shredders have been ordered there will be some sites that will not receive a shredder.
1196	Commissioning intentions are to have an integrated team between social care and health working and co-located together .It is unclear as to what the future commissioning intentions are however there is potential that health staff could move into social care structure, loss of jobs, and potential for loss of reputation, pooled budgets and joint management .Overall risk to Barnet potentially is that loss of key services could lead to other existing services becoming unviable within Barnet. Unable to address risk due to the unknown quantity from the risk itself	12	Possible	Major	12	4	29/10/2014	28/04/2017	Shillingford, Elizabeth	Finance, Performance, Contracts and Strategy	Business Continuity	North Division	Intermediate Care, Rapid Response and SPA	Intermediate Care	The integration has been signed off by the Health and Well Being board from last year Integrated Steering group in place with all providers and commissioners present ,has risk register and other governance structures CCG committed at a high level to delivering this ,as is a nationally led objective Core member of monthly working group Finances in place and now agreed for pilot till September 2015. Currently working through funding to April 16 Integration team is in place and taking patients	Evidence base in circulation that Integration is not the magic bullet ,NAO paper noting that savings previously attributed are not foreseeable nationally Mini- evaluation has taken place with no clear outputs/recommendations. further evaluation to follow but no timeline. Evaluation results of pilot scheme may impact on strategic direction Discussion underway about expansion with no clear parameters established	Continued commitment to integration programme Key members of Integrated Care steering group and HSC Integration Board That commissioning intentions remain currently committed to delivering this integration	Lack of clarity regarding possible expansion

1203	Potential cost and disruption to Trust headquarters associated with proposed refurbishment of Westminster City Hall by Westminster City Council (WCC), including increased rental for premises occupied by the Trust.	16	Unlikely	Major	8	9	18/11/2014	31/01/2017	Daccus, Ian	Finance, Performance, Contracts and Strategy	Estates and Site Management	Corporate Services		Estates and Site Management	Discussion with landlord to understand the time and extent of challenge Proposed vacation of trust headquarters at Victoria Street under 15/16 QIPP programme	Programme for refurbishment currently unconfirmed Landlord proposals for tenants during refurbishment unknown Alternative premises to be identified Lease break to be negotiated and delivered	PMO to review schemes QIA approval by Medical Director Lead Nurse	Lack of information provided by landlord
1273	In addition to the 0.5% cash releasing commissioner QIPP modelled in the IBP/LTFM, there is a potential risk that the Commissioners may ask for an additional 0.5% cash releasing QIPP. The financial impact of this will be on the Trust's I&E position and Cash Balances.	12	Unlikely	Moderate	6	6	24/03/2015	31/05/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	Accurate costing for SLR allowing Trust to benchmark internally and externally		continued 3 year strategy to remove 30% of overheads costs annual reference cost submissions	
1274	In addition to pay inflation modelled in the LTFM, the NHS pay arrangements may be reviewed and amended and a further 0.25% is requested. The financial impact of this increase would be against the Trust's I&E position and cash balances. This risk is out of the control of the	6	Unlikely	Minor	4	4	24/03/2015	30/06/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	LTFM is reviewed on a quarterly basis with inflation assumptions being updated as appropriate due to internal or external intelligence on the issue		Inflation assumptions are part of the LTFM and IBP which is reviewed and approved by ELT, FRIC and Board	

1275	In the LTFM/5 year plan Non-Pay inflation is currently modelled at 2.2%. However this risk assumes that non-pay inflation increases by an additional 0.5%. The financial impact of this risk will be against the Trust's I&E position and cash balances	6	Unlikely	Minor	4	4	25/03/2015	30/06/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	External Advice on level of anticipated NHS non-Pay Inflation and tariff guidance issued annually by DofH		Inflation assumptions are contained and reviewed as part of the IBP by ELT, FRIC and Trust Board	
1276	To achieve Foundation Trust Status the Trust must achieve a continuity of service risk rating of 4. The financial plan is currently achieving this. This risk assumes that current liabilities exceed our current assets by more than £3.5m in any one year and the CSRR rating will fall to a '2'	5	Rare	Catastrophic	5	5	25/03/2015	30/06/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	Ensure that the Trust's current assets are greater than our liabilities Managed cash balances Regular LTFM updates which reviews/updates the CSRR, and is always being monitored		Reviewed by FRIC to maintain healthy cash balances Part of the FT application is to review this as PART of the LTFM updates Request by Monitor that The Trust does not fall below a 3 CSRR rating	
1277	This risk assumes that the Trust's Debtor days (ability of our customers to pay the Trust) increase from the current 24 days to 45 days. The financial impact will be on the Trust's cash flow and ability to pay our customers/staff (creditors)	5	Rare	Catastrophic	5	5	25/03/2015	30/06/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	Credit Control Management maintain healthy cash balances maintain and improve strong relationships without commercial contracts team & commissioners		These are reviewed monthly by the Divisional Director of Resources and Performance and where appropriate it will be escalated Debt over 90 days old should not exceed 5%. Preparation of annual rolling cash forecasts reviewed by FRIC	

1350	Lack of accurate performance data (e.g. under/ low activity/ high DNA's etc.) following transfer to SystmOne could lead to loss of business and have a reputational impact with the CCG's.	15	Rare	Catastrophic	5	5	07/07/2015	02/05/2017	Greenleaf, Dan	Finance, Performance, Contracts and Strategy	Data Quality	South Division		Strategy and Performance	Performance Information Data Quality Operational Group (PIDQOP) group meeting fortnightly All issues are escalated to head of Performance in the same week that the data is available Head of performance to work closely with head of BIPA to address all issues Monthly performance meetings Monthly CCG meetings Internal cross-divisional meetings CRIB sheets for S1 users to ensure correct data input There have been SystmOne Surgeries for all services Robust data validation to be undertaken weekly	None currently identified	Minutes from performance and CCG meetings Performance pack to Board Analysis of data at service level Identification of themes/ trends	None currently identified
1375	CCGs may devolve the prescribing budgets for CLCH services and non-medical prescribers which currently stands at ~£1.5million. CLCH will then be financially responsible for managing these budgets and any associated cost pressures e.g. annual uplifts.	12	Possible	Major	12	4	04/09/2015	31/07/2017	Butt, Arfana	Finance, Performance, Contracts and Strategy	Medicines Management	Corporate Services		Medicines Management Team	Full database held by MM team of all CLCH NMP prescribers. Prescribers are all coded to the correct CCG code to inform accurate prescribing costs. Services prescribing on FP10s have been identified since 2013 and also held on a MM database. Therefore the overall level of prescribing activity within the Trust is known. ePACT prescribing data can be accessed for Barnet directly and for inner borough services via the CCGs and is shared with line managers of prescribers every quarter. Full years' worth of prescribing costs available for 2014/15. Prescribing data is to be shared with CBU managers from Sep 2015. Head of MM is linked in with the Heads of MM for inner borough and Barnet CCGs. Discussions have been held with Barnet CCG re: a transfer date of 1st April 2016. NMP policy is in place.	Database is constantly changing with changes in staff. Uplifts to budgets and any associated cost pressures will have to be picked up by CLCH, budget to be identified for this.	Database is maintained by B6 Technician. Monthly review with Leavers and starters list. ePACT data is pulled quarterly for all prescribers and sent to line managers of prescribers	Assurance required from managers that prescribing data is being reviewed for appropriateness

1377	CLCH may be acquiring Medicines Management Risks and substandard clinical practice when winning new business as the MM Team have no extra resource within the team to make the necessary assessments during the due diligence stage through to business as usual. This year, there has been a 30% increase in the number of clinics requiring MM input. This does not include Harrow and Merton.	12	Possible	Major	12	4	04/09/2015	31/05/2017	Butt, Arfana	Finance, Performance, Contracts and Strategy	Medicines Management	Corporate Services		Medicines Management Team	Business case for 1 x 8b pharmacist and 1 x B5 Technician for new services (Hertfordshire Sexual Health, West Herts Respiratory, Brent School Nursing, Hounslow Diabetes, Richmond School Nursing, Hounslow School Nursing) approved 02.12.15 Currently the Deputy Head of MM is the contact for providing input into tenders and mobilisation groups as input needs to be an 8b pharmacist or above. Commercial bids team inform MM when services are being tendered for.	Job description and recruitment to start for 8b pharmacist post Merton and Harrow mobilisation commenced Nov 2015 requiring support from existing resource Other duties are not reduced therefore input and attendance is ad hoc	Recruitment started for B5 technician. Post out to advert w/c 08.02.16 Merton and Harrow mobilisation are being prioritised as go-live dates are 1st April 2016 Deputy Head of MM aware of new services being won and the work that will need to be done with the teams to reach business as usual	Work coming out e.g. policy review, review of MM systems at clinics, merging of practice is not always possible to prioritise due to competing demands and maintain BAU service. MM input to Harrow and Merton mobilisation requiring prioritisation as go-live dates 1st April 2016
1385	Unable to meet compliance targets due to a number of different contributory factors including: new induction process not yet embedded implementation of Windows 7 affecting ESR therefore staff unable to access e -learning stat/man training smartcard access to SystmOne -affecting access to ESR/e-learning booking.	12	Possible	Major	12	8	02/10/2015	31/05/2017	Daley, Marcia	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services			Stat/man policy, annual training calendar, Daily communication, Monthly compliance reports to Board, ADQs, CBU managers and HR Business Partners, Monthly reminder emails to staff, intranet publications. new e-induction process in place	implementation of windows 7 affecting access to ESR as part e-learning	confirmation of meetings and agreed action plan between L&D and IT	none identified at present
1391	Risk of fragmenting service and loss of partnership working due to commissioning intentions for 16/17 likely to include market testing of diabetes services in inner boroughs.	12	Likely	Moderate	12	3	06/10/2015	31/03/2017	Ebenezer, Peter	Finance, Performance, Contracts and Strategy	Business Continuity	Inner Division	Long Term Conditions	Diabetes Services	Diabetes Board Business and Strategy Board Established partnership between CLCH/ Imperial and Chelsea and Westminster	Diabetes Board has not made a decision for a partnership approach to bid Business and Strategy Board have not forged links with partner organisations to agree joint working	Minutes of Diabetes Board Minutes of Business & Strategy Board	

1407	GPwSi Budget does not cover the cost of running the service putting CLCH at financial risk i.e. running the service at a loss. as a result of increased demand in Service and use of Agency GPwSI.	12	Likely	Moderate	12	2	16/10/2015	31/07/2017	Prevost, Audrey	Finance, Performance, Contracts and Strategy	Financial Risk	Inner Division	Specialist Nursing	Dermatology	To have increased Funding from commissioners To remodel the service to meet current funding level	Level of funding does not cover cost of current service provision		
1412	Core services do not meet contractual standards (transitional milestones). Dip in performance as services transition and transform causes failure of Partnership to deliver expected service based benefits with linked impact on the Trust's finances and financial goals.	8	Unlikely	Moderate	6	4	16/10/2015	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Strategy and Performance	Service performance is being baselined for the contractual KPIs so an accurate understanding of current performance levels is established. Operational performance will be monitored and reported to the Operational Board and any issues escalated to the Management Board.	There are several KPIs which are yet to complete the baselining period and KPIs which have been agreed are no longer applicable and need to be revised.	KPI reporting against SLA has been established. Baseline measurement of performance to be continually reported at Ops Board. Performance to date with one or two small blips has been on target or above.	Better assurance required of KPI/PI data that is used to quantify and develop performance reports.
1427	Governor elections as part of the Foundation Trust process fail to: - secure full Council of Governors (COG) - achieve sufficient turnout - achieve representative COG This would result in scrutinisation by NHSI and could represent a potential challenge to Foundation Trust status.	12	Possible	Moderate	9	4	26/10/2015	31/12/2017	Walbridge, Ms Jayne	Finance, Performance, Contracts and Strategy	Administration	Corporate Services			FT Steering Programme - routinely review risks Database of people interested in becoming governors established Formal consultation planned Feb 2017 at which point we hope to generate interest in standing for election to the council Membership strategy in place Election plan ready for go-live once go ahead given by NHSI		Chair and Trust Secretary have regular meetings on position Updates on governance and membership to FT Programme Group	

1430	No letters of support from central London commissioners influences the TDA's decision to refer the Trust to Monitor. If referred it may influence Monitor's decision not to authorise the Trust as an FT.	8	Possible	Moderate	9	4	26/10/2015	31/05/2016	Mills, Joe	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services		Strategy and Performance	Associate Director of Strategy is leading on development on Stakeholder Engagement Plan Working closely with the TDA to ensure limited impact	Stakeholder engagement plan not signed off No letters of support received from central London commissioners	Deputy CEO monthly updates on stakeholder engagement to Board	Still awaiting referral to Monitor FT application 'paused' with TDA until June 2016
1440	The use of system one electronic core care plans is resulting in nursing staff not individualising patient specific care plans. This is resulting in patients not feeling that they are being involved in planning their care. The impact of this risk is potentially affecting both the KPIs within the positive patient experience domain around 1. Proportion of patients whose care was explained in an understandable way 2. Proportion of patients who were involved in planning their care.	12	Likely	Moderate	12	4	04/11/2015	28/04/2017	Jones, Darren	Finance, Performance, Contracts and Strategy	Clinical Treatment	Inner Division	Community Nursing - Tri Borough		System 1 has the ability to individualise electronic core care plans via a 'free text' function. Health records keeping audit, monitors the use of personal care planning involvement and is used to identify specific teams that are not achieving the set standard	There is currently limited support around the clinical interface and use of system one for patient related care. Community nurses continue to focus on the patient home paper records, as the main patient record.	Health record keeping audit in place. Once the current support around ensuring data entry on system one is meeting our business performance requirements, this current support will switch focus to the use of system one clinical interface. This will include personalised care planning.	There continues to be a need for patients to be made fully aware that they have been involved in planning their care, especially when they are being asked this question from a patient experience collection process, i.e. via Picker.

1446	If G4S are unable to meet the transport demands for CLCH then this could lead to patient dissatisfaction and poor reputation.	15	Likely	Moderate	12	2	11/11/2015	02/05/2017	Greenleaf, Dan	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services	Corporate Services	Strategy and Performance	Monthly contract meetings Escalation plans in place Agreed documented processes re. Datix incidents e.g. turnaround times etc. G4S user reference group set up Review of accuracy of data is undertaken monthly Third party providing additional support to main contract	Eligibility criteria to be agreed/ signed off and implemented Completion of action log (see attached) Comms reminder to staff specifically on the criteria/ protocol Training with staff on new criteria Patient transport user group to be established Cleanse approved list of bookers Training and Comms to be focused on the list of bookers Patient transport Policy to be written	G4S KPI's Monthly contract meeting minutes Reports to contract meeting/ Divisional Board/ PSRG	
1451	Because the investment portfolio fails to achieve a good return, the objectives of the funds cannot be met.	9	Possible	Moderate	9	6	19/11/2015	31/03/2017	MacDonald, Robert	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Funds are managed by Cazenove who provide regular information on performance against target Charitable Funds Committee considers fund performance at least three times per year Quarterly CLCH specific investment reports initiated in March 2016 Regular review of committed expenditure against funds available Funding commitments, including recurrent, non-recurrent and new requests for Pembridge are considered at least annually	Expenditure at Pembridge currently exceeds income - fundraising manager has been appointed and strategy is being implemented During 2016 the market has been volatile, possibly due to a combination of worldwide uncertainty and the impacted of the referendum / decision leave the European Union. Regular reports are being provided by Cazenove, including an anticipated amplification in market volatility, underlining the need for diversification of investment.	Regular financial reports from Cazenove considered by Charitable Funds Committee Minutes from Charitable Funds Committee meetings	

1453	Failure to manage income and expenditure exposes funds to fraud / financial loss	9	Unlikely	Moderate	6	3	19/11/2015	30/06/2017	MacDonald, Robert	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Standing orders and standing financial instructions apply to charitable funds Charitable funds are subject to external audit which includes consideration of fraud Dedication charitable funds account manager appointed 2015 Monthly report on investments now being provided routinely to members of the committee Application form guidance includes clear process and financial limits Discrepancy in relation to Committee consideration (all bids in excess of £3k) now resolved and communicated via bid form	Countersignature requirements in relation to funds not well understood and must be addressed	The charitable funds committee routinely reviews income and expenditure at meetings External audit - clean opinion confirmed 2015.16	
1461	Charitable fund expenditure guidelines are not followed resulting in expenditure which is not compliant with fund objects	6	Unlikely	Moderate	6	3	23/11/2015	29/06/2017	MacDonald, Robert	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Requests for funding in excess of £3k must be considered by the Committee Guidance in relation to the use of charitable funds for staff social events now formalised and included in the application form Guidance issued by the Association of NHS Charities in relation to staff benefits considered in detail - March 2016 There is an approvals process and all expenditure greater than £1k must be countersigned by the Director of Finance, Contracts and Performance		The Charitable Funds Committee now routinely receives a report on expenditure in excess of £1k	

1510	If we are reporting inaccurately on clinical performance data (e.g. waiting times data), then there could be a potential risk to delivery of patient care. Furthermore whilst performance data being delivered by BIPA is not fit for purpose, there is risk that staff are diverted from patient care to produce clinical performance data. (Financial and reputation elements of this risk captured in BAF risk 1218)	12	Possible	Major	12	4	17/12/2015	31/03/2017	Hale, Elizabeth	Finance, Performance, Contracts and Strategy	Data Quality	Corporate Services		Strategy and Performance	Fortnightly adults SystmOne working group meeting Escalation to head of BIPA Divisional Board discussions Head of performance cross references BIPA and service data on a monthly basis Review of how the waiting times are currently calculated and reported has been completed	Review of how the waiting times are currently calculated and reported	Confirmation that waiting times and reported times are correct SystmOne working group meeting Emails to head of BIPA Copy of minutes of Divisional Board	None currently identified
1524	Core services do not deliver transformational milestones (e.g. e-expenses) because of delays in delivery of Trust dependencies. This results in transformed services not delivering expected financial savings targets.	12	Possible	Major	12	4	14/01/2016	14/10/2016	Mellor, Matthew	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			There is clear definition and agreement of Trust dependencies for each transformation project. Monitoring of Trust deliverables is happening through Transformation project management. Utilise escalation processes when required. Definition and agreement of Trust dependencies for each are currently being worked through as part of the weekly Commercial meeting.	Monitoring of Trust deliverables needs to be reported to Ops Board and issues discussed and agreed.	Every Operations Board now has 'Transformation' as a standing agenda item to ensure consistent sighting on milestones. PAP team to begin testing the service user experience (such as recruitment, e-expenses). A new Transformation report is to be produced by the SP in conjunction with the Client unit tracking more clearly than before the delivery of the Trust's dependencies.	Trust Dependencies (responsibilities) are currently being worked through but are some issues with gathering supporting data.
1525	As Capita transfer services out of Trust offices/buildings, large areas become vacant without the supporting occupancy fees relied on to pay for them.	6	Unlikely	Moderate	6	1	14/01/2016	31/01/2017	Daccus, Ian	Finance, Performance, Contracts and Strategy	Estates and Site Management	Corporate Services			Trust have appointed Ian Daccus as their joint Director of EFM and as such the estates transformation plan fully aligns. Estates transformation plan to align with Capita exit plan. Additionally, Capita have a gainshare incentive to increase savings by ensuring costs are kept to a minimum.	Partnership team needs greater assurance on the detail and progress of EF&M strategy.	Trust have appointed Ian Daccus as their joint Director of EFM and as such the estates transformation plan fully aligns. Occupancy monitored monthly across all services to determine impact	Reviewed and none identified.

1536	Interoperability: TPP failed to commit development resources to the CH2 / GP Referrals In work stream in May 2015 as anticipated, the fully automated solution could not be delivered until the development took place and this commenced in October 2015. Due to TPP not committing development resources the two projects CH2 and GP Referrals In have missed their deliverable dates (Sept 2015) and they will remain red until they are fully delivered.	4	Unlikely	Minor	4	1	05/02/2016	31/05/2017	Chronias, Andrew	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	IMT	Regular communication with account manager and development team. Escalation to Project Board attended by TPP Account Manager.	Lack of any obvious capacity for contractual or punitive enforcement of project requirements.	Regular, minuted Project Board meetings.	Limited capacity to affect TPP's strategic or commercial view.
1551	The Tri-borough and Barnet CaSH external webpage does not meet the needs of services users. It is an essential part of increasing access to the service, widening its reach and modernising the service and it does not adequately address any of those objectives. This is a risk to the competitiveness of services in relation to winning up and coming bids	12	Likely	Moderate	12	6	01/02/2016	03/07/2017	Mbogo, Mark	Finance, Performance, Contracts and Strategy	Financial Risk	South Division	Specialist Nursing and Sexual Health	Sexual Health Services	There is an accurate external webpage for the CASH service	Standalone website designed specifically for the client group	Seen as a priority by the Trust Comms team - short and medium term plans agreed with service to address Key aspect of the service bid as part of tendering process 16/17	

1584	Changes in key members of personnel within the Partnership's (Trust and Partner) structure may result in a delay in progress of current/future projects and temporarily reduce the capacity and effectiveness of the Partnership.	9	Possible	Moderate	9	1	17/03/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services			A prioritised plan is in place between the two client units to ensure progress is continuing to be made despite changes in personnel that may occur.	Reviewed and none identified.	Progress updates on personnel changes will be given at the Strategic Partnership Management Board, which is attended by the Director of Finance, Resources and Performance.	The SP Management Board meeting cycle has recently been adjusted to every two months, reducing reporting frequency.
1585	Interoperability: Diagnostic Cloud CQUIN: The printing requirements for Pathology requests and the importance of the ability to print have only become clear post ICE testing, too late to be included in the current scope of the MPS project. The inability to print the specialist labels may impact upon the take-up of the diagnostic cloud across requesting services within CLCH. This may impact upon the achievement of the second qtr. 4, milestone which carries a value of £118,489.	6	Unlikely	Moderate	6	2	17/03/2016	31/05/2017	Chronias, Andrew	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	IMT	Frequent, regular contact with printer suppliers (Brother, Canon) to establish possibilities for solution	Possibility that no printer exists to meet service requirements. The output of available printers does not meet service requirements. Services refuse to take up Dx ordering without having their specific printing requirements met.	Regular updates about CQUIN progress, including printing requirements, are provided to Board.	

1598	BAF Risk: Sustainability and Transformation Plan (STP) Resource. Risk that the Trust has not allocated adequate resources to the engagement with the STP process in the four geographies where CLCH provides services - NWL, NCL, SWL, Herts. This could mean that the Trust's strategic interests and the interests of community healthcare are not sufficiently represented in the development of the STPs.	12	Unlikely	Moderate	6	6	18/04/2016	31/05/2017	Medhurst, Dr Joanne	Finance, Performance, Contracts and Strategy	Policy	Corporate Services			STP discussed weekly at ELT to drive actions/focus across senior management Shared calendar of events and nominated director leads to ensure resources & updates are in place Assessment of project scope and resource requirements by new STP Director STP Prioritisation Approach agreed at ELT September 2016 STP management under new ELT member Director of Improvement	Previous gaps have now been addressed through STP Director and apartment	ELT, FRIC and Board updates on STP progress by STP Director	None evident as action updates are brought back through STP Director report
1605	If performance data is not produced accurately and on time by BIPA, there is a risk that Sexual Health service (in Barnet and Inner London) will not be able to meet contract requirements.	9	Likely	Moderate	12	3	25/04/2016	06/06/2017	Mbogo, Mark	Finance, Performance, Contracts and Strategy	Data Quality	South Division	Specialist Nursing and Sexual Health	Sexual Health Services	Community Information Manager, South Division are currently running the reports for Merton Quarterly contracts meetings Temporary data reports are produced by BIPA team Initials meetings held between DDO & BIPA to formalise reporting	Formalised agreement from BIPA Agreed SOP's for data recording	Minutes of the quarterly contracts meetings	Copy of formalised agreement from BIPA Copy of SOP's for data recording
1641	Mobile Working: Benefits realisation delay due to the delay in organising the phase 1 Quality Impact assessments and subsequent Quality Impact assessments for phase 2 and 3 of mobile working implementation	12	Likely	Moderate	12	3	01/06/2016	30/06/2017	Chronias, Andrew	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services		IMT	QIA process approved for mobile working deployment. Request for dates sent for phase 1 Continual diary liaison- PSO liaising with the PA's for medical director and chief Nurse to arrange suitable dates for all QIA sessions. Importance and relevance of QIA regular agenda item at Mobile working design group	Availability of core attendees is limited at short notice Dates for Phase 2 &3 being sent in advance	QIA documentation prepared in advance for each QIA session Up-to-date schedule provided to all attendees. QIA sessions all complete. Action for each service line decided at QIA session, some benefits to be realised as part of wider QIPP planning.	

1642	If we are not successful in winning the Inner London Sexual Health tender there will an impact to the Trust income, loss of staff and possible redundancies.	12	Possible	Major	12	4	01/06/2016	01/04/2017	Mbogo, Mark	Finance, Performance, Contracts and Strategy	Financial Risk	South Division	Specialist Nursing and Sexual Health	Sexual Health Services	Financial modelling has been completed Tender will be submitted on time Project team meets every Tuesday Project risk register in place	None currently identified	Action tracker from the project team meeting Copy of the risk register. Copy of the tender.	All KPI's will be reported on.
1647	Mobile working: Benefits realisation delayed due to being unable to monitor and understand changes in productivity as KPIs dashboard not yet available from BIPA	15	Likely	Moderate	12	4	03/06/2016	30/06/2017	Chronias, Andrew	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services		IMT	Placed as a Priority 1 data set Escalation due to delay Meeting confirmed method of capture Time frame for completion and delivery of benefits agreed for each of the QIA sessions Further time frame clarification made to ensure data is with CBU manager a minimum of 6 days prior to QIA session to allow review of data and incorporation into the QIA documentation	complex information set needs to be understood before time scale on delivery can be given		Data capture method agreed signed off and produced on a monthly basis. No information beyond May 2016 received from BIPA, Information needed to enable review of productivity changes post implementation of Mobile working
1675	The Strategic Partnership costs the Trust more than budgeted for as a consequence of the: - Allowable Assumptions - Trust Responsibilities - Legacy Issues - Financial True Ups which the Trust has contractually agreed to enable Capita to deliver the Transition and Transformation models we have agreed.	12	Possible	Moderate	9	6	17/06/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services		Financial recovery plan in place. Alternative sources of revenue reduction across the Capita service streams (IM&T, HR, E&FM, BI and Finance) sought to mitigate any in-year under delivery. Negotiation is underway with Capita to mitigate financial exposure in the Strategic Partnership service areas.	Ambiguity in the Partnership contract, resulting in lack of clarity over where financial responsibility lies. There remain some residual commercial Allowable Assumptions and Trust Responsibilities to be resolved. Their resolution needs to be escalated to the Management and Partnership Boards. This is in process but will require a review of the commercial mechanisms agreed within the Contract (e.g. day rates)	Series of meetings scheduled to address the two major contributors to financial risk within the Partnership: Estates budget and IM&T packaged applications. Target to update FRIC on 21st July. Prior escalation, if necessary, is scheduled for the Partnership Board on the 5th July and ELT on the 13th July. Raised at the August Partnership Board.	Dependency on joint review and agreement of propositions provided by the Trust in a timely manner.

1695	Poor alignment of governance will reduce the Partnership's effectiveness. Decision making process is inefficient resulting in potential benefits not being realised.	12	Likely	Moderate	12	6	11/07/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services	Corporate Services		Stronger governance around the Partnership Board so as to include all CLCH Exec Directors and CLCH Counterparts. Clearer alignment of the Partnership Board to the Trust Goals and feedback from the 9 month review.	HR governance can be approved, due to duplicate/resource interview meeting Review pof HR governance - aim to streamline and improve effectiveness	Regular debriefs to review effectiveness of meeting/ feedback from Partnership Board in August Partnership Board and Management Board.	
1696	The Partnership will limit its growth potential if its unable to develop or agree new projects/services	12	Possible	Moderate	9	6	11/07/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services			Opportunity pipeline to distinguish growth potential which is external to the Trust and that which is internal. External opportunities to be more explicitly managed through the Management and Partnership Boards. Partnership Board themes and Execs sponsors More focus on growth agenda - bids More regular contact between Trust and Capita colleagues at the right levels Discussion around STPs	Review different appetite to risks - e.g. bid pricing A Forum to discuss growth opportunities	Partnership Board and Management Board Successful tendering tracking Growth Commercial Theme Setting up Forum to discuss growth opportunities	
1700	That staff employed at CLCH, funded by charitable funds may at some point be eligible for redundancy if funding does not continue.	6	Unlikely	Moderate	6	4	13/07/2016	30/06/2017	MacDonald, Robert	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Redundancy liability is monitored at least annually Value of fund(s) is monitored at least 3 times per year by the Committee Bids are made annually, including continued funding of posts / initiatives for the following year Funds are subject to external audit annually In the event of redundancy, the standard NHS redeployment arrangements will apply	The charity is unable, within accounting rules, to make a provision for redundancies	Charitable funds are subject to annual, external audit A dedicated charitable funds account manager is in place, providing regular finance reports for Committee consideration	Ensuring that there are sufficient funds to meet any future redundancy payments is not subject to external audit as it cannot be included in the accounts

1719	If there is a delay in temporary staffing linking agency shifts in allocate then there could be discrepancies between the actual and reported agency spend data for the South Division Community Nursing Services.	12	Rare	Moderate	3	3	08/08/2016	09/05/2017	Danks, Alison	Finance, Performance, Contracts and Strategy	Data Quality	South Division	East Locality (Merton)		Fortnightly call with temporary staffing/ Capita Dedicated temporary staffing lead contact Weekly Agency Breach meeting Issue was raised at the Temporary Staffing Summit Rostering policy	None currently identified	Minutes from the Weekly Agency Breach meeting	
1722	Procurement QIPP savings are not delivered due to lack of resource/capacity (staffing) in the team.	12	Possible	Major	12	8	11/08/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	Initial plan for resolution is to agree a long term service model to be potentially provided by Capita. Deadline for agreement mid Sept 2016. Failing this, the secondary plan is to recruit fully to a new team of 5 FTE's to replace current interim arrangements provided by capita - due to expire end of Sept 2016. Verbal agreement with capita that if long term service model cannot be agreed, they will continue to provide a support service to allow sufficient time for the permanent recruitment to take place. An options paper will be presented to ELT on 2nd November. The paper will present the output from a review of outline business case from both Capita and other NHS potential procurement partners (NEL CSU and NWL STP). In addition this paper will present options on providing additional short term procurement resource to deliver outstanding procurement opportunities.	The support service that will continue if a service model cannot be agreed would be a reduced service compared to what is in place at present, reducing the capacity and effectiveness of the Procurement service. Time taken to fully recruit a permanent team of 5 FTE's means an extended period of time with reduced support directly reducing the ability of the team to deliver all savings opportunities and the QIPP savings plan for 2017. Plan for Capita to agree a long term service model is only a verbal agreement at this stage.	Long term service model, if agreed will be agreed through the Schedule 23 governance of the Strategic Partnership. Recruitment of 5 FTE's will be facilitated through the Trust's established recruitment process.	Time taken between possible failure to agree long term service model and recruitment of permanent 5 FTE's.

1741	Poor communications between key staff for the Trust and Capita runs the risk that issues are not identified and addressed, contractual milestones are missed and we do not optimise the output/deliverables from the Partnership. The consequence of this risk materialising could be poorly performance partnership services; extra cost of service delivery; strained relationships; and less resilient services (i.e. not able to deal effectively with problems).	6	Possible	Minor	6	4	12/09/2016	15/03/2017	Greenaway , Charlene	Finance, Performance, Contracts and Strategy	Communication	Corporate Services	Corporate Services	Strategy and Performance	• Better staff handover and documentation to improve retention of knowledge within the Partnership; • Piece of work to more clearly define roles and responsibilities across the Partnership (out of review) • Strengthening governance arrangements to provide tighter grip on issues and to ensure appropriate forums (fora?) are in place to discuss and resolve issues. • Planning set of workshops in 2017 to improve understanding of how Partnership works (e.g. CCN process) Leadership to define and reinforce effective management behaviour Revisited escalation process Awareness the commercial deal in the contract Growth agenda - partnership strategy to include growth	Meeting not yet set up	Exec sponsor meetings for comms and culture (Partnership Board Level) Monitor at weekly Partnership catch up • Tracking of any priority issues at Partnership Directors weekly catch-up • Tighter grip of issues at Operations Board • Working on strengthening the escalation process for the Partnership • Communications and Engagement Partnership Theme (Executive Sponsorship) actions – reporting to Partnership Board	Currently unknown
1742	A lack of joint accountability and ownership of problems runs the risk of developing a "blame culture" between Trust and Capita services, which runs the risk of delaying activity to address issues/problems, as they arise. The negative consequences could be to leave contractual and commercial issues unresolved, the Partner not having commercial cover to undertake work and potentially leaving work/activity uncompleted which negatively impacts on frontline patient care	12	Possible	Major	12	4	12/09/2016	14/06/2017	Greenaway , Charlene	Finance, Performance, Contracts and Strategy	Service Delivery	Corporate Services	Corporate Services	Strategy and Performance	Escalation process Better coordination Commercial fortnightly meetings Tackle underlying issues that drives behaviours Shareds trackers - understand common position Stronger Partnership governance (e.g. CCN process) to minimise impact operational services • Greater willingness/ability to recognise and talk about issues, • Establishing forum/fora for each service which have decision-making authority to resolve problems	Implementation and Review	• Tracking of any priority issues at Partnership Directors weekly catch-up • Tighter grip of issues at Operations Board • Working on strengthening the escalation process for the Partnership • Service Quality & Commercial Themes (Executive Sponsorship) actions – reporting to Partnership Board Continue to monitor timescales for completion of CCNs and contractual milestones Earlier detection of and resolution of problems	

	and staff.																
1754	If the continence products budget is not reconciled for Merton, the budget is estimated to be overspent for 2016/ 17 by 250k. This is a financial risk to the division.	10	Possible	Minor	6	2	28/09/2016	02/05/2017	Mbogo, Mark	Finance, Performance, Contracts and Strategy	Financial Risk	South Division	Specialist Nursing and Sexual Health	Continence Care	Continence caseload has been reviewed to ensure it only has Merton patients The projected spend at disaggregation has been reviewed & identified the costs allocated to the budget are not adequate therefore cost pressure has been raised	CBU and finance manager to meet to reconcile budget	Comparison of patients reported on ONTEX (pad service) vs RIO	Comparison of patients reported on ONTEX (pad service) vs RIO Population based analysis of usage of pads

1777	Due to changes in European procurement regulations that commenced on 18 April 2016, NHS England have decided that they must advertise NHS contracts that usually rolled over via annual negotiation. So far NHS England have only published tenders for specialised services which do not include CLCH services, however it is clear than technically all commissioners should do likewise. Therefore there is a risk that CCG commissioners could put out adverts for CLCH current contracts that run till 31st March 2017. Or that other organisations could legally challenge commissioners who do not do so. This raises risk against approximately £90m of CLCH income	12	Unlikely	Major	8	4	21/10/2016	15/09/2017	Wright, Tom	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services			Links with NHS contracts leads in London to share knowledge and anticipate any likely impact or occurrence of risk Links with NHS Providers national body to ensure their lobbying and support on commissioners and national policy makers		Current commissioning intentions published for main CCGs do not identify any intention to tender services Contracts & New Business Report identifying published tender adverts and CLCH responses	
1778	Delays/ difficulties in the current process for requisitioning and generating Purchase Orders are creating delays in payment and overdue payment to suppliers. This leading to legal action threats and removal of access to estates and services provided by suppliers. This in turn may lead to disruption or inability to provide contracted clinical services.	12	Likely	Moderate	12	3	01/11/2016	29/04/2017	Daccus, Ian	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services	Corporate Services	Estates and Site Management	Process for Request of PO and Invoice payment through integra Finance Escalation of risk to Head of estates and transformation lead for Finance	Process for requesting PO's in advance to be followed for costs were known in advance. completion of Audit of room space used by Hounslow diabetes service to ensure estates costs are not above what is used by service Full list of SLA, contract agreements for estates costs to Hounslow Diabetes to be agreed		audit on Hounslow community diabetes estates use.

1783	Not signing Change Control Notices (CCNs) within prescribed timescales leads to multiple risks for the Strategic Partnership: • Negative impact on operational services (responding to changes in operational needs) • Not being able to close projects on time (transitioning change into business-as-usual activity) • Capita not having sufficient commercial coverage to undertake work • Not having a mutual understanding in advance of output deliverables and timescales before work is undertaking • Undermines the financial monitoring of the Partnership • Lost QIPP opportunities by delaying opportunities to take value added/improvement work through the Partnership	4	Possible	Major	12	9	08/11/2016	15/03/2017	Stobie, Adrian	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services	Corporate Services	Strategy and Performance	This risk is managed by the Trust and Capita Partnership teams through: Regular monitoring of CCNs on the CCN Log and reporting to the Operations Board. Weekly catch-up calls to review open CCNs for IM&T and HR. Weekly catch-up with Partnership Directors for high priority CCNs that need closing. Introduction of a prioritisation matrix to focus staff resource in closing down CCNs	The Partnership teams are addressing the following gaps in controls: Sufficient staff time to maintain the CCN log. Sufficient staff time across the Partnership to progress the CCN outstanding points	Monthly reporting to the Operations Board	TBC
1797	Risk that the Trust will have less flexibility to enter into New Care Models/Joint Ventures as it is not an FT and there is a national pause in FT programme.	12	Possible	Major	12	4	27/01/2017	30/04/2017	Wright, Tom	Finance, Performance, Contracts and Strategy	Business Continuity	Corporate Services			Trust strategy review led by CEO with update to Board Engagement with NHSI and NHSE around options for New care Models Legal advice on ability to enter into JVs as an NHS Trust		Legal advice on ability of an NHS Trust to enter into JVs Updates on national FT Program Updates on Trust intentions with respect to New Models of care	

1821	There is a financial and reputational risk to CLCH due to the potential loss of the MSK contract with BCCG for not consistently meeting the 56 days waiting times target.	12	Likely	Moderate	12	2	10/03/2017	30/06/2017	Abdulla, Valerie	Finance, Performance, Contracts and Strategy	Business Continuity	North Division	Specialist Nursing and Therapies and Learning Disabilities (North)	MSK Physiotherapy	Commissioner agreed action plan and trajectory to meet the 56 day target. Agreed sub -contractual arrangement with other provider to see 400 new patient contacts to address the waiting list.	Staffing levels reduced due to long term sickness and maternity leave may impact on meeting agreed trajectory. GAPS in staffing level in single point of access can impact on flow of referrals to the service which results in a backlog.	Reduction of waiting times over the period of action plan and trajectory Weekly performance report to assure that agreed action plan is effective.	
1838	Bank staff may be engaged in the same role for over 24 months may acquire employment rights which could result in unforeseen financial liability for redundancy or unfair dismissal	6	Possible	Minor	6	2	12/04/2017	30/06/2017	Boynton, Emily	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services						

831	BAF Risk: Failure to deliver the 2016/17 QIPP (£10.7m) results in a reduced surplus or a deficit and an adverse change in our financial risk rating (from a 4 to a 3 or lower). (QIPP target for 2016/17 of £10.7m, contingency of 10% against potential shortfall)	16	Likely	Minor	8	8	15/08/2013	28/02/2017	Fox, Mike	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services	Corporate Services	Finance	SROs appointed. Monthly QIPP reporting to ELT, Finance Committee and Board in place. Monthly monitoring of QIPP performance at Performance Improvement Meetings. PMO function established Q1 and Q2 reserves review which went to the ELT and finance committee included the following mitigations which should help the QIPP position: : 1) Deferment of investments identified at annual business planning; 2) Further review of reserves at Q3 and 3) Updated plans for QIPP Further work underway to quantify benefit from agency savings which will help to address the remaining shortfall	Finance support to Transformation is overstretched due to multiple pressures from planning timetable and contractual negotiations PIDs to support plans to deliver full QIPP target require further development	•PMO and Transformation Director validation of QIPPs (+). Monthly transformation dashboards (+) Internal Audit Review of CIPs process (+) Clinical Assurance through the QIA process chaired by Trust Chief Nurse & Director of Quality Governance and Trust Medical Director.	Review of the QIA policy regarding QIPP required

859	BAF Risk: Service redesign and key partnership plans of new clinical models not completed and/or communicated in an effective or timely manner, jeopardises key contracts or FT application.	15	Possible	Major	12	8	19/08/2013	31/01/2017	Ashley, Louise	Finance, Performance, Contracts and Strategy	Financial Risk	Corporate Services		Strategy and Performance	CLCH representatives at all external contracting/performance/ Shaping a Healthier Future and Whole Systems Integrated Care Project Boards Jointly agreed SDIP reviews and co-design of improvement •Monthly meetings of Transformation Board. Chaired by Deputy CEO •Contracting round planning meetings attended by Operations, Nursing and medical Directors. Community nursing transformation programme initiated to address concerns relating to model of care in CN. To be communicated via special presentation to PCE. Also links in to WS work where CLCH have developed a core role in both the WL and CL CCG programmes. Active engagement is enabling mitigation of the risk of losing CN contracts Engagement with Imperial as Lead Health Provider partner on CIS service has demonstrated CLCH delivery of new clinical model Community nursing transformation programme initiated to address concerns relating to model of care in CN. To be communicated via special presentation to PCE. Also links in to WS work where CLCH have developed a core role in both the WL and CL CCG programmes. Active engagement is enabling mitigation of the risk of losing CN contracts Continued engagement with commissioners regarding development of STP plans and CLCH involvement in the shaping of outcomes. New timetable of business planning and contractual negotiations identified within Q3 Q4 2016/17 and shared with Directors	Risk management and governance structures in place for programmes could be improved for WS as programmes are evolving.	Transformation board progress report to ELT, FRIC and Board monthly Attendance at contracting round (meetings/process) and monthly CQG/PCEs WS programme update to ELT and Board on regular basis. Supported by transformational team.	Cross organisational (external) joint programme plans and milestones.

875	There is a risk to the organisation that internal post can get lost or in the hands of another company as we currently have three different contracts. H&F are using Imperial, K&C and Westminster are using NWL and Barnet are using CL property services.	9	Possible	Moderate	9	3	22/08/2013	16/09/2016	Codrington, Lee	Finance, Performance, Contracts and Strategy	Estates and Site Management	Corporate Services	Corporate Services	Estates and Site Management	Annual data flow mapping Use of Internal post is included in the annual Information Governance training Transfer of Information and Safe Haven policy currently advises staff not to send PID via internal post PHS property now pick up internal post from main CLCH sites	PHS do not pick up from all of the small sites or schools PHS are not picking up the new services we have recently taken over for example Hounslow diabetics, West Herts sexual health, Brent school nursing Reception is no longer controlled by estates	Data flow mapping has been completed 23/10/14 Data flow mapping is being completed with staff to see how information is being processed Incident reports are being reviewed to check for incidents where internal post has been used discussions between estates, IG and NHS PHS to try and clarify the situation	Data flow mapping is showing that staff are sending information through internal post Incident reporting is showing that staff are using the internal post for PID
695	There is a risk to the organisation that neither procurement or estates can provide a list of all the different companies who take away CLCH confidential waste. Leaving us open to possible fines if our information is not destroyed in an appropriate way.	9	Rare	Moderate	3	3	29/05/2013	31/08/2016	Burns, Lesley	Finance, Performance, Contracts and Strategy	Estates and Site Management	Corporate Services		Estates and Site Management	Information Governance are creating a working group to look at this problem	No co-ordination No control of contractors policy No approved contractors list	All companies now identified and contracts in place	Process to be confirmed
521	SystmOne data needs to be input on a daily basis to reflect District nursing activity and reflect activity for commissioning reporting. Currently temporary staff do not have access to SystmOne which means that a paper system has to utilised and input by admin when they are available. Permanent staff are not always inputting data within 24 hours. Impact of loss of contract income and contract itself.	12	Unlikely	Moderate	6	4	04/03/2013	28/04/2017	Cupid, Wendy	Finance, Performance, Contracts and Strategy	Financial Risk	North Division	Community Nursing Services - Barnet	District Nursing	Staff are all required to input within 24 hours and this is monitored weekly Monthly process to ensure all activity is completed before expenses are signed off Discussed at weekly team meetings	Demand outstripping clinical capacity Mobile working for District Nurse's Allocated RIO/ SystmOne time within the daily visit allocations	weekly activity reports are run from Rio weekly reports - discussed with Band 7 DN team leaders , cascaded to staff , staff who continue not to outcome their activity - will be performance managed.	None currently identified
Fire, Health and Safety																		

1007	The Trust may not be able to provide sufficient evidence of compliance to the CQC to satisfy Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [Safety and Suitability of premises].	20	Likely	Minor	8	6	18/11/2013	29/09/2017	Daccus, Ian	Fire, Health and Safety	Estates and Site Management	Corporate Services		Fire Health and Safety	A Compliance Project Officer was appointed to carry out surveys at CLCH sites to identify areas of non-compliance. The Project entails scoping out and planning the extent of the visits needed to be undertaken on CLCH sites in order to assess the risks on those premises; to write up reports of the findings and to devise an action plan to mitigate the identified risks. The project also requires the Trust to engage with other key stakeholders such as NHS Property Services, and Local Authorities to ascertain the extent of the statutory assurance documentation that they possess and to which CLCH can have access. These surveys were completed in September 2014. Issues of non-compliance have been identified and included within the capital programme. The capital programme for 2014 is split into two packages, the first of which commenced on site at the beginning of October 2014 and will complete in January 2015. This first tender included all items from the compliance reports that had been completed by the end of June 2014. The second tender will address the remaining reports (approx 15) and will take place Jan to March 2015. 17032015 AAGB, Compliance accessibility and H&S survey conducted by Oakleaf, reports and action plans prepared in Feb 2015. The actions from above are included in the Phase 2 works. Compliance folders will be delivered to each CLCH site by 27/03/2015. Meetings with NHS PS personnel have been held. CLCH have been instructed to raise, in the first instance issues with PS help desk.	Should the Health and Safety Executive (HSE) visit the Trust (as a result of an incident for example) then again the Trust may not be able to promptly provide suitable and sufficient assurance that it is compliant with all the statutory provisions of the Health and Safety at Work etc. Act 1974. •Further resources will be required to bring this project to a satisfactory conclusion. The above issues have now been resolved as a result of the production and distribution of compliance folders to each of the CLCH sites. •There is a risk that should the CQC visit to inspect any Trust premises; providing timely assurance of compliance with Outcome 10 requirements may not be readily forthcoming.	All relevant sites have been risk assessed and a report with recommended remedial actions completed. A programme to implement the recommendations is underway through the capital programme. A series of bi-monthly meetings are being undertaken between CLCH and NHSPS to exchange information to provide assurance of Outcome 10 requirements CLCH estates managers have access to NHSPS Technology Forge for INNER sites, and limited access to MICAD databases (where compliance docs are held) to seek assurance on current compliance. •Additional meetings with other local authorities and stakeholders are also planned as a key part of the project. Compliance folders are located at each of the CLCH sites.	•Population of the TF database is complete, for purposes of efficiency the Barnet properties have been loaded onto the TF database.

1200	Staff, when in need of support via a panic alarm may be at risk if the alarm: 1. Is not present. 2. Is present but not working. 3. Is working but there is no follow-up or response procedure.	12	Possible	Major	12	4	12/11/2014	22/03/2017	Daccus, Ian	Fire, Health and Safety	Estates and Site Management	Corporate Services	Corporate Services	Estates and Site Management	Clearer procedures in place Alarm checks on a monthly basis by caretakers and clinicians to check on a weekly basis/E&F managers Annual maintenance contract in place through NHSPS Each room has a personal 'Rape/Attack' alarm which can be heard at the main reception counter. There is a Security Officer in the WIC reception during opening hours.	NHS PS are unable to repair the alarm system. None identified	Manual testing undertaken by caretaker (monthly) Clinicians (weekly) /E&F Manager/reception Seek positive assurance in E&F monitoring reports	NHS PS have undertaken an assessment of Panic Alarm needs (20/04/2015), the Trust is awaiting the report!
1283	The Trust is currently Non-compliance (due to incomplete actions) with Annual CAS alert: 'Window restrictors of cable and socket design' (EFA/2014/003). The alert expired on 31.03.2015. (This alert issued by CAS requiring on-going review and assessment (particularly following any relocations, refurbishment and reassignment of premises from non-clinical to clinical facilities).	9	Possible	Moderate	9	3	01/04/2015	31/03/2017	Basham, Andy	Fire, Health and Safety	Estates and Site Management	Corporate Services			In CLCH owned sites and clinical areas of non-CLCH owned sites, E&F managers have reviewed all areas within their domain for non-compliance. NHSPS reviewing non-CLCH owned sites. Trust owned sites with patient access have been assessed in all sectors. Status reports have been produced and actions are being addressed (Original control, see S/N 1 above for revised control (for discussion at H&S Committee))	Whilst the site safety checklist references window and blinds, it does not refer specifically to checking window opening restricting devices. Whilst window restrictor checks are now included in the SEA (secure environment assessment questionnaire) as part of the annual H&S audit programme, the programme is yet to be carried out due to resource limitations. Some non-CLCH owned sites are yet to be inspected. NHSPS have completed checks in primary care and bedded areas and are now progressing with health centres as their 3rd phase of inspections. Part of a program of works that is scheduled to work 4-6 months (from beginning of July 2015). Checks are only as good as the day they are carried out. There have been instances where staff have removed restrictors to improve ventilation in clinical areas without taking into account the impact such actions may have should an unauthorised person gain access to a room whilst unattended.	Annual site safety reports will identify any shortfalls or changes in existing window security status. Each site manager holds details of the inspections that have been conducted. Available on request.	Site safety audits are only carried out annually, and changes can be effected to window security at any time, therefore the possibility exists for a window to be compliant on the day of the audit/site safety inspection, but overridden the next day. No centralised document detailing compliance/non-compliance in respect to window restrictors across all CLCH sites (check with Roveena to confirm that this is the case)

1284	Ligature injuries or death may occur due to incomplete action to close-out CAS alert EFA/2015/001, 'Window Blinds with Looped Cords or Chains (all types)'.	12	Unlikely	Catastrophic	10	5	01/04/2015	28/04/2017	Basham, Andy	Fire, Health and Safety	Estates and Site Management	Corporate Services	Corporate Services	Estates and Site Management	In CLCH owned sites and clinical areas of non-CLCH owned sites, E&F managers have reviewed all areas within their domain for non-compliance. NHSPS reviewing non-CLCH owned sites.	Whilst the site safety checklist references window and blinds, it does not refer specifically to checking window blind pull cords. Some non-CLCH owned sites are yet to be inspected. NHSPS have completed checks in primary care and bedded areas and are now progressing with health centres as their 3rd phase of inspections. Part of a program of works that is scheduled to work 4-6 months (from beginning of July 2015). Whilst cord ligature checks are now included in the SEA (secure environment assessment questionnaire) as part of the annual H&S audit programme, the checks have not yet been carried out due to resource limitations.	Each site manager holds details of the inspections that have been conducted. Available on request	No centralised document detailing compliance/non-compliance in respect to cord ligature across all CLCH sites (check with Roveena to confirm that this is the case).
1307	Non-compliance of CAS alert:DH/2014/003-Reminder For The Testing Of Fire & Smoke Dampers And Ensuring The Integrity Of Fire Stopping	9	Possible	Moderate	9	6	01/05/2015	31/08/2017	Daccus, Ian	Fire, Health and Safety	Estates and Site Management	Corporate Services			NHSPS responsible for conducting testing of fire and smoke dampers on sites where such exist	1. Excessive time taken by NHSPS to complete surveys due to the requirement for raising a contract prior to work being undertaken 2. Capita are have requested but NOT received written confirmation that NHS PS are conducting Annual Fire Damper Assurance checks.	NHSPS will provide annual fire and smoke damper risk assessments and reports	1. Trust needs to contact NHSPS 3-6 months in advance of annual report requirement to ensure assessments and reports are undertaken
1379	Actions incomplete for CAS alert: EFA/2015/003 -Flush Fitting Vandal And Tamper Proof Light Fittings In Mental Health Environment And High Risk Areas	15	Rare	Catastrophic	5	5	10/09/2015	28/04/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services						

1388	Patients, Staff & Visitors may be harmed because site-based risk assessments are not in place at Trust Tier 1 and 2 sites.	12	Unlikely	Major	8	4	05/10/2015	31/08/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services	Corporate Services	Fire Health and Safety	Prior to occupation, inspection and audit is carried out by the FHS team before commencement of contracts. Formal reviews, monitoring and audits by managers and FHS team in line with Trust Health and Safety Policy as well as workplace checklists to be undertaken monthly by managers and annually by H&S team and reported to H&S Committee.	Lack of resources within H&S team has resulted in audits and inspections not being carried out in FYr 14/15. Workplace inspections before commencement of contracts are carried out by FHS team as best practice however these are not explicitly detailed in the H&S policy. This requirement is currently known by existing employees however turnover of staff could result in 'corporate memory loss' and therefore failure to complete this task. H&S audits and inspections review 'H&S workplace checklists' which ought to be carried out by managers on a monthly basis. There is currently inconsistency in the completion of these checklists. Currently no training in place to teach managers how to complete an H&S workplace checklist.	Results of H&S audits and inspections carried out by the FHS team are disseminated to divisional team leads, E&F, infection prevention and control, security and NHSPS as appropriate Since current FHS manager assumed appointment (June 2014), all premises used by services in new business contracts have been FHS assessed. Records for all new premises are available from the FHS team and project leads.	Although it is understood that managers may be undertaking local H&S audits as recommended in the policy, there is little/no assurance that these are being completed, since they are kept 'in house' (barring instances where issues must be escalated to H&S) Currently no quarterly report that summarises the outcomes of audits. Even where evidence is collected it is not currently being disseminated We do not have assurance that all business won prior to the arrival of the current FHS Manager has been FHS inspected

1389	Lack of access controls leads to increased possibility of falls and other accidents.	10	Unlikely	Catastrophic	10	5	05/10/2015	28/04/2017	Basham, Andy	Fire, Health and Safety	Estates and Site Management	Corporate Services	Corporate Services		Swipe card and Digi-lock access is installed in some CLCH premises (e.g. Edgware Community Hospital). Alarms on emergency doors where there is a risk of unauthorised access to high locations.	Uncertainty over number, location and status of sites with potentially accessible high locations. Identification of 'at risk' high locations is not currently included as part of the Trust H&S inspection/audit programme. Possibility that not all premises have swipe card and digi-lock access to upper floor areas that ought to have restricted entry. There are premises where door alarms are not installed on access and egress points to high locations (e.g. South Westminster Centre second floor outpatient emergency escape route – permits access upwards or downwards without controls). Risk is more pertinent for individuals with capacity issues – especially in multi-occupancy premises where the Trust does not have ultimate control over access and egress (i.e. Tier 3 sites). (Key: Tier 1- Sites owned by CLCH Tier 2- Sites where CLCH is a tenant but also Head Lessee; Tier 3- Where CLCH is a tenant).		Information on 'at risk high locations' currently not shared with H&S committee as part of a paper.

1390	Asbestos Containing Materials embedded in Trust freehold, leasehold or occupied premises may cause injury if not managed properly.	15	Unlikely	Catastrophic	10	5	05/10/2015	30/06/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services		Fire Health and Safety	Control of Contractors policy ensures works cannot be undertaken without the contractor going through a rigorous approval process. This policy also states that risk assessment and method statements will be submitted for Trust approval in advance of major works taking place. Management of Asbestos and Associated Procedures policy requires that any works to the fabric of a building shall be subjected to a review of the asbestos management plan before approval for works to go ahead can be granted. IT, Estates, NHSPS and 3rd Party project management company have received training and communication in respect of Trust policy and asbestos identification. The Procurement department are required to bring 'Control of contactors' and 'asbestos & associated procedures' policies to the attention of all contractors. In all CLCH sites where asbestos has been identified, there is a twice yearly inspection by a competent contractor to assess its state. Where there is deterioration an action plan is produced and implemented. Post project reports are being completed by ISS and NHSPS E&F Managers maintain work activities on site and address accordingly Monitoring of sub-contractors training to be carried out by project manager from Inglewood Ltd and Phil Corser for Capita IT Infrastructure Compliance monitoring of projects is being carried out by Tim Pullan of Ingleton Wood Ltd, E&F Ops managers and E&F Managers.	Lack of full control of all contracts carried out on Trust premises and those owned by NHSPS. Initial training for new E&F employees and refresher training for existing employees in relation to Asbestos. Post project reports ought to be completed by Procurement or project leads however at present no assurance available that these are conducted Management of Asbestos and Associated Procedures Policy states that Monitoring reports (completed through the life of a project) should be submitted annually, as well as after removals and singular events. No assurance that this is being conducted. Currently all E&F Staff have attended Asbestos Training. There is a very slight chance that works could be approved/undertaken by a new team member who has not received training. There is potential for a breakdown in communication to result in the relevant information (re. harmful substances)not being identified to contractors. .	Risk assessments and method statements conducted prior to work commencing are sent to E&F team and are available for review. Asbestos management plans (detailing where it is in every building) are produced annually by 3rd party contractors are available on request	Post project and monitoring reports currently not available for review and audit

1392	Patients, staff & visitors may be injured or harmed due to lack of suitable and sufficient incident / fire evacuation plans	15	Unlikely	Catastrophic	10	5	07/10/2015	31/08/2017	Cooke, Bill	Fire, Health and Safety	Health and Safety Hazards	Corporate Services		Fire Health and Safety	1. Fire Risk assessments undertaken at all sites, including evacuation procedure checks. 2. Fire Drills conducted as per Trust policy. 3. Fire Safety policy available on the HUB. 4. Local Induction checklist available on HUB. 5. Fire Awareness training available to all staff and managed through ESR records by L&D 6.Fire Warden zones identified and detail available on HUB. 7. Fire Warden training is available monthly through L&D. 8. The Trust has a Fire Safety Policy which states a requirement for fire wardens to be in place at each site. 9. A comprehensive set of PEEP's are available for guidance on the HUB 10. Leavers information received from HR ensures that the fire warden matrix is accurately maintained	1. Training not currently available to managers on how to provide effective local inductions. 2. Local induction checklist not being used 3. Staff working in multiple premises are not receiving local induction training 4. Insufficient fire wardens in place 5. Evacuation plans not available at all sites. 6. Staff not trained to use Fire Evacuation Equipment 7. Fire Drills not in place in Tier 2 sites. 8. Fire procedures exist in site folders but staff are not availing themselves of them.	1. Copies of the Fire Risk assessments are saved on the F drive and are also available from the FHS team. 2. Results of the Fire Risk Assessments (where major changes made) presented at the Strategic Estates Group, and Trust H&S committee in the Fire Safety Report 3. Fire Warden matrix, detailing site information available to DDO's. 5. An asset register exists for fire equipment 4. Fire drill reports available for Tier1 and 2 sites.	1. Local induction training is not documented, managers not forwarding to FHSM or to L&D that policy is being complied with. 2. There is no assurance that fire warden requirements are met on site by site basis. 3. Whilst a fire equipment asset register exists, it does not include new business sites.
1394	Breached or missing fire compartment barriers in Tier 1 premises, in particular, Bedded units could result in more rapid spread of smoke/fire within a property than is intended by a building specific fire strategy.	15	Rare	Catastrophic	5	5	07/10/2015	31/05/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services		Fire Health and Safety	1. Control of Contractors Policies implemented 2. Fire doors/ sets are checked as part of CLCH Fire Risk Assessment 3. NHSPS and ISS check fire doors as part of 6 monthly PPM. 4. After CLCH Capital works are completed Fire Risk Assessments are carried out prior to occupation	1. Lack of post project inspection proforma for CLCH Capital works. 2.checks not being carried by third party contractors. 5. Premises managed by 3rd party landlords (not including NHSPS) yet to confirm compartmentation check in walls and ceilings. 3. NHSPS 3rd party compartmentation survey contract on hold, during NHSPS restructure. 4. Premises managed by 3rd party landlords (not including NHSPS) yet to confirm fire doors being checked 6 monthly.	1. Annual Fire Risk Assessments (FRA's) kept on 'F:' drive. 2.	1. Compartmentation breaches identified in either post project inspections (IT , Capital works) or during FRA's are not formally reported to the HSC. 2. FRA's not provided for new business premises as per due diligence.

1395	Risk of not being able to evacuate bedded units in a safe and efficient way where fire is detected.	20	Unlikely	Catastrophic	10	5	07/10/2015	31/08/2017	Cooke, Bill	Fire, Health and Safety	Emergency Preparedness	Corporate Services		Fire Health and Safety	1. Policy states that CLCH should comply with DoH guidelines which recommend fire drills are carried out twice yearly. 2. CLCH staffing numbers on wards overnight, combined with 3rd party assistance (Sanctuary Care, NHSPS Porter etc.) provides sufficient numbers for fire evacuations. 3. Evacuation equipment is available at all sites, to aid patient evacuation (vertically) 4. Bank and Agency staff receive a local induction prior to start of shift 5. New fire training course specifically for bedded units added to the ESR system to monitor training records. 6. Evacuation equipment video available on HUB to support face-to-face training. 7. Radios available on all bedded units, providing communication with others in the building.	3. Current fire alarm panel displays inaccurate information (Athlone House) 4. Escape from garden area restricted with padlocks (Athlone House) 5. Patients being left in cold at assembly point (all bedded sites) 6. Fire Evacuation procedures not approved by London Fire Brigade 1. Fire Evacuation plans adopted but not yet been approved or tested. 2. Local training on evacuation equipment not carried out between the formal training courses.	1. Training attendance information is available for all staff from Learning & Development via ESR 2. Fire drill report, following the 6 monthly drills 3. A list of evacuation equipment across the Trust is retained in a Fire Safety folder on the Trust 'F' Drive.	1. No fire drills / reports started 2. No Asset register for evacuation equipment 3. No % training reports to highlight current position per site. 4. Management of commercial radio licences with bedded sites.
1396	Use of extension leads and multi-outlet sockets can lead to increased risk of electrical fire.	10	Unlikely	Catastrophic	10	5	07/10/2015	30/06/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services			All staff are informed of the risk associated with the use of extension cables and socket overload during their Mandatory Fire Awareness training. Topic additionally covered in the Fire Warden training. Workplace risk assessment being done by the Estates and Facilities team during their monthly checks.	1. Insufficient permanent power sockets in some areas. 2. No detailed understanding of the extent of the problem on a site-by-site basis 3. Extension lead questions are included in H&S workplace checklist however there is no consistent approach to undertaking these. 4. Workplace Risk Assessment not being done consistently. 5. Responsibilities for completion of workplace assessment not clarified in the Health and Safety Policy.	Assurance provided by L&D of staff attendance for both the Fire Awareness and Fire Warden training.	1. Not currently part of the fire risk assessment process therefore no annual assurance available (in form of post assessment report).

1397	Risk of trips and falls due to poor cable management in the Trust.	9	Possible	Moderate	9	3	07/10/2015	28/04/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services			Cardinus questionnaire asks about cable management and prompts individuals to make amendments or report matters that they cannot resolve to their line manager. H&S awareness training covers identification of cable management issues and prompts attendees to contact their line manager or H&S. Workplace risk assessment being done by the Estates and Facilities team during their monthly checks.	Some staff have not completed the Cardinus online DSE assessment package. There is inconsistency in the completion of H&S checklists by E&F managers and managers. At present there is reference to H&S checklists in the H&S policy however these are not contained within the said document. Insufficient number of trained and appointed safety representatives across the Trust. Under the Safety Representative and Safety committee regulations, safety reps can undertake tours and inspections accompanied and unaccompanied using checklists, however, this is not being done currently. Workplace risk assessments not being completed consistently for all sites. Responsibilities for completion of workplace assessment not clarified in the Health and Safety Policy.	Cardinus update presented to H&S committee on a quarterly basis – recorded in the minutes and available on request Records of H&S awareness training attendance are held by L&D and are available on request.	Update on Cardinus to H&S committee is verbal rather than paper based. H&S checklists are not available for external review, no assurance that these are being conducted.

1402	Risk of MSK injuries to staff from use of workstations as a result of incorrect setup, incorrect use and non-compliant work stations.	9	Likely	Moderate	12	3	13/10/2015	18/08/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services			DSE policy available to all staff on the Hub. This covers legislation, training requirements, equipment setup and assessments relating to fixed and agile working with desktops, laptops and tablets. Process in place whereby starters are identified by HR and details forwarded to FHS team on a monthly basis to be processed for training. Staff are sent invitations to complete the mandatory Cardinus online DSE training and self-assessment package. Work station setup is physically demonstrated to staff undertaking the mandatory H&S awareness training. Face-to-face assessments are available for staff who require further support (referrals can be from self, manager, employee health and Cardinus). There are 59 questions in the Cardinus online DSE assessment checklist. These are used to identify non-compliant equipment. On completion of Cardinus questionnaire the system automatically sends the employee recommended actions and details of peripheral equipment to improve their working conditions.	As of June 2015 12.1% (364) of the workforce had not started/completed the online Cardinus DSE assessment training. Whilst it is understood that invitations have been sent to everyone, there are new starters (yet to complete), those whose jobs do not include regular access to computers, and those who are aware but non-compliant. Cardinus programme identifies users of laptops and tablets however at present there is not stand alone mobile DSE working training. Whilst the DSE policy states that in the event of a change in circumstances or workstation another risk assessment should be undertaken, this is reliant on self-referral/managerial referral.	Data from Cardinus identifies who has completed the training, as well as any remedial actions for individuals. These records are presented quarterly at the H&S committee. H&S awareness training attendance is recorded and available on request from L&D.	The update at H&S are verbal rather than paper based. This makes audit difficult and there is potential for them to be excluded as a result of time pressures.

1404	Risk that H&S policies are not maintained leading to a breach of compliance with regulations and increase in other Health & Safety risks in the Trust.	9	Possible	Moderate	9	3	13/10/2015	31/08/2017	Basham, Andy	Fire, Health and Safety	Policy	Corporate Services			Policy for the Development and Management of Procedural Documents states that it is the authors (H&S team) responsibility to ensure that Policy documents comply with all relevant legislation and up to date evidence. Policy review group tasked with disseminating details of which policies are due for review. H&S team receives notifications (from Barbour health & safety information service) when legislation changes – prompting review of CLCH policy.	Where consultation is required from external experts during policy development/review, there is no guarantee of the timescales for response potentially resulting in policies deadlines being missed. Barbour health & safety information subscription in under FHS managers name (not a corporate subscription). In the event of staff turnover, there is potential for oversight in future.	Minutes from PRG meeting (in which any upcoming policy deadlines are discussed) available on request	H&S team do not keep a live document of the policies and their upcoming work plan.
1610	Mobile Working: Risk of MSK injuries to staff from use of mobile devices as a result of inappropriate set up and use of DSE by users, and the lack of peripheral equipment to enable safe working at devices at all times. This Risk to link with risk 1402, held by Fire, Health and Safety.	16	Likely	Moderate	12	3	27/04/2016	31/08/2017	Basham, Andy	Fire, Health and Safety	Non-Medical Equipment and Devices	Corporate Services			DSE policy Agile strategy H&S information in Training sessions Mandatory DSE Assessment and training for desktop and laptop users MW-DSE Work group	Agile strategy review required to extend cover to clinical use/mobile workers Current H&S advice given in MW training using currently held information. Updates will be needed as further guidance is developed DSE assessment specific to table use is not yet in place MW -DSE work group developed during implementation	Ongoing monitoring of Datix, User guidance is being prepared and will cover portable devices implemented as part of agile working, project deployment and IMT mobilisation trust wide, Formulation of portable devices Health and safety work group. First meeting held 12th July.	

1638	Risk that Mobile working Project may not be able to fully implement with minimum DSE and health & safety recommendations. Risk to productivity, financial and practical benefits of the current project.	15	Likely	Moderate	12	6	27/05/2016	30/06/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services		IMT	DSE policy Agile Strategy H&S information in Training sessions Mandatory DSE Assessment and training for desktop and laptop users. Cardinus training package includes Mobile/Agile user guidelines and questions. MW- DSE work group Development and costing of minimum required safe working equipment set. Back packs/rucksacks are available following risk assessment should staff members require them. Advice on the packs is available from the MH lead.	Budget not in place for provision of these equipment's against mobile working deployment	Business case of financial support to providing necessary equipment as a result. Portable devices Health and safety work group has been formulated and the purpose is to look at securing health & safety of staff through the use of portable devices Trust wide. Membership of the group includes representation from: FH&S, moving and handling, estates MW project, clinical, staff side/union H&S and IMT. The distribution of back packs is a mitigation for moving & handling of IT equipment.	
1639	There is a perceived risk that the non-inspection of 'Void Spaces' (above ceiling tiles) is placing staff and visitors to Trust owned or leased sites at risk of being unable to safely evacuate premise in an emergency, caused mainly by un-viewable and unidentified breaches in 'Fire Stopping'. This is known as 'poor or lack of compartmentation' and puts all persons at risk in an emergency situation	10	Unlikely	Catastrophic	10	5	27/05/2016	31/05/2017	Cooke, Bill	Fire, Health and Safety	Health and Safety Hazards	Corporate Services		Fire Health and Safety	1. control of Contractors policy implemented 2. fire doors are checked as part of the Fire Risk Assessment 3. Fire doors are checked as part of ISS PPM every 6 months 4. After CLCH Capital Works are completed Fire Risk Assessments are carried out prior to occupation	1. lack of post project inspection proforma for CLCH capital works	1. Compartmentation breaches identified in either post inspections (IT, capital works) or during FRA's are not being formally reported to HSC	

1653	There is a risk to the safety and security of staff and patients attending the Soho WiC. Additionally the WiC does not open without a security officer on site. When this is not available or delayed there is a risk to access to services for patients, inability of the service to meet contractual obligations, and risk to the good reputation of the service: 1. Access to the clinical consultation rooms not secured with open access to all 2. Lack of robust consistent security cover or appropriate management of such	12	Unlikely	Moderate	6	3	13/06/2016	31/05/2017	Cuff, Andrea	Fire, Health and Safety	Security	North Division	Walk In Centres / Urgent Care Centres		Personal attack alarms for permanent staff. Also one on each desk of clinical room for non-permanent staff and at reception. WiC employed Security Guard on duty	No formal service standards in place/Assignment Instructions Lack of feedback/meetings to feedback issues with service provision	Datix incidents reviewed Risk reviewed at North Divisional Board	
1785	There is a risk from the insertion of socket covers, or their breakage whilst in use, as they can allow foreign objects to be inserted directly onto live parts within the socket, thus presenting a high risk of electric shock. CAS alert EFA/2016/002.	9	Possible	Moderate	9	6	05/12/2016	28/04/2017	Daccus, Ian	Fire, Health and Safety	Estates and Site Management	Corporate Services			Socket protectors are being checked as part of the Site Safety Assurance Assessments by FHS and E&F staff. Annual and Regular checks are being carried out because staff have been known to replace removed socket protectors.	Staff have been known to replace removed socket protectors the same day and soon after removal. Regular check therefore being carried out.	FHST and E&F managers are conducting annual and periodic checks to ensure socket protectors are not being used.	Failure to conduct annual or periodic checks might result in injuries being sustained
1792	If a SLA / contract / sharing of business continuity plan is not agreed between CLCH and Sanctuary for emergency and fire response, there is a risk that patient and staff safety will be compromised	12	Possible	Major	12	4	11/01/2017	30/06/2017	Jones, Ian	Fire, Health and Safety	Business Continuity	Inner Division	24 Hour Services	Bedded Rehabilitation (Athlone)	Proactive communication between CBU Manager and Sanctuary Proactive communication between CBU Manager and Capita Estates Lead Discussed and minuted at EPRR Meeting Discussed and minuted at Divisional Board	No SLA in place between CLCH and Sanctuary	Regular communication between CBU Manger and Capita (Rob Stewart) CBU Manager now has contact at Sanctuary to escalate issues Local Business Continuity Plans in place	

1819	This is a risk that there may be breached, or missing compartmentation barriers above suspended ceilings in Tier 2 properties (Non-Bedded units) that are owned by NHS Property Services, and which are in part or in whole occupied by CLCH Staff and Services.	10	Rare	Catastrophic	5	5	07/03/2017	28/04/2017	Basham, Andy	Fire, Health and Safety	Health and Safety Hazards	Corporate Services			NHS PS have established a contract with a Third Party compartmentation assessor and remedial contractor. Work plan to follow from NHS PS.	NHS PS survey and works programme not yet presented to Capita for review and commencement.	Once NHS PS work programme in place it will be monitored by The FHSM and FSO.	No evidence of works or action plans exist or will do so until work programme has commenced.
275	Risk to staff experiencing violence, bullying, harassment and abuse from patients, relatives and public.	9	Possible	Moderate	9	3	20/05/2010	31/08/2017	Faulds, Ron	Fire, Health and Safety	Corporate Risk	Corporate Services	Corporate Services	Resilience and Compliance Team	POLICY - Violence & Aggression at Work (incorporating processes for escalating sanctions applicable to the level of offending) POLICY - Lone Worker (incorporating processes for risk assessment and management of lone workers) POLICY - Health & Safety (incorporating requirements for health and safety of staff whilst at work, legislation, etc. and identification of risk) POLICY - Incident Management (incorporating the processes and procedures for the identification, reporting and management processes following incidents involving violence, aggression, abuse, etc.) POLICY - Bullying & Harassment (incorporating the reporting process and management procedures) REPORTS - The management and investigation of incidents involving violence, aggression, etc., etc., are reported through the following processes : LSMS / SMD Briefings (Monthly); LSMS / AD R&C Briefings (Daily/ad hoc); Board & NHS Protect (Annually); H&S Committee (6 weekly); H&S Sub Group (6 weekly); DATIX Incident Reporting Database (ad hoc); Risk Assessment Review (ad hoc) LEARNING & TRAINING - The Trust provides mandatory Conflict Resolution Training	RISK ASSESSMENT DATABASE - the absence of a database or other established facility to collate all security, lone working and violence & aggression risk assessments prevents regular review by the LSMS "SKYGUARD" Personal Safety Lone Worker Devices - the process for rollout is yet to be completed thereby facilitating an opportunity to accurately assess the value of the investment, in conjunction with a planned staff survey	Qualified LSMS in post, compliant with Codes of Conduct laid down by the Secretary of State Evidencing staff attendance and completion at CRT Security Management Standards - Annual submission of SRT for sign off by the Board and CEO LSMS / LCFS / Other local LSMS Liaison Meetings LSMS / Local Police Liaison Meetings H&S Sub Group - Security Reports (6 weekly) DATIX investigation methodology for inspection, information and staff feedback	

														(incl. Refresher sessions) to all frontline staff, whilst the LSMS provides localised security management and awareness (incl. lone working) to individual as well as Team meetings				
Information Governance																		

1154	BAF Risk : Failures in adherence to Information Governance national standards can lead to reputational damage, conflict with regulatory compliance and undermine the quality of Trust service delivery.	16	Possible	Major	12	8	15/07/2014	31/05/2017	Fox, Mike	Information Governance	Financial Risk	Corporate Services	Corporate Services	Information Governance	2016/17 IG Toolkit Action Plan being overseen by IGG Annual mandatory Training Information Governance training is available both on-line and face to face Information Governance policies are available on the Hub IG team send regular reminders out to staff via the trusts daily news. E-faxing solution has been rolled out Trust wide Encrypted email solutions has been rolled out Trust wide IG team restructured and IG/Risk Manager active in IG adherence Records Manager facilitator recruited The IG Toolkit audit for 2015-16 with TIAA has concluded and the Trust evidence and assessment accepted. 19/10/15 Update – A 12 month view of incidents with recommendation is due to be submitted to ELT on the 28/10/15 to provide information around the themes and trends of incidents. ICO action plan was completed on the 31/10/2014 and signed off by the IGG and CEO 03/11/2014 Data Mapping work programme was completed in October 2014.	Although E-faxing solution has been rolled out along with the encrypted email solution the uptake is low	IG Toolkit Leads identified and working on Toolkit submissions with oversight by IGG The IG Team has increased its communication campaign with weekly communication via the communication team to raise awareness of IG. The IG Team has also started their annual Data Protection audits with a total of 8 out of 8 completed to date. Face to face training still takes place monthly as well as the facility being available online. As new services join CLCH the IG Team aims to continue to provide training to staff outside normal classroom sessions. 16/02/16 - The Trust has obtained 95% IG Training compliance. Audit of the IG toolkit by the trusts auditors gave substantial assurance in 2015/16. IG Training achieved 95% in February 2016. Weekly communications from the Information Governance team included in the trust updates. Incident reporting is a standard item for the Information Governance group There are 770 Egress users and 194 EFax accounts IG work plan approved with progress and milestones submitted to IGG bi monthly All incidents now reviewed and recoded. Findings report was submitted to CQG in September 2014 and there was acceptance of work carried out and assurances given. ICO Work programme approved by IGG. Updates to be provided to the Information Governance group New Information Governance posters delivered to sites. The ICO final audit report with work programme was signed off by IGG on 03/11/2014. This included works undertaking to reduce and mitigate risks	Not all incidents are being coded correctly so the Information Governance team sometimes do not know incidents have happened until sometime after the event

1586	Patient Confidential Data could be lost or misplaced by staff members that have access to the CLCH current data solution. Currently there are no technical restrictions on access to the CLCH network using unauthorized devices, this is controlled through policy, training and instruction. Technically staff members could extract and take out entire CLCH patient dataset's onto personal devices and take it out of the trust or partnership control, this is against policy. Potentially if an unauthorized device is stolen or misplaced the data could end up in the public domain.	12	Unlikely	Moderate	6	3	21/03/2016	22/05/2017	Chronias, Andrew	Information Governance	Security	Corporate Services			The Trust has policies which prohibits the use on unencrypted devices on the network to store data. This is further reinforced in the IG training given to staff. Staff are also advised of approved encrypted USB sticks that can be used The situation has been discussed with key stakeholders from Capita and CLCH. At the moment an action plan is being put together on Capita site covering BI to address the key risk areas. Entire BIPA team has been asked to complete mandatory IG training and was asked not to use personal devices to connect to CLCH network. This will need to be extended to cover other relevant areas. Risk is being monitored by IGG.	Locking down the network to unauthorised devices. The completion of relevant training and extension of enforcement of the policy to other areas is yet to be completed pending identification of the 'other areas'.	An action plan has been shared between BI and IMT and Trust colleague to address the key risk areas. The entire BIPA team have completed mandatory IG training now and have been instructed NOT to use personal devices to connect to CLCH network. The action plan needs formally agreeing and enacting. AC: NHS requirements and CLCH policy are for all portable devices and storage in use to be encrypted, use of an unencrypted device would be a breach of policy, this is reinforced in annual IG training. A further report to be brought to Operations Board in May by JM/ AC / PC updating on this risk and the actions that are in place. Bi monthly risk report submitted to IGG which provides update on the status of the work that is being carried out to manage this risk.	Due to a change in the cycle of the Operations Board, at the time of writing the action plan has not been shared with the Operations Board. This will take place on Mon 16th May 2016.
1613	The centralised process for archiving is not recurrently resourced either centrally or within Divisions to deliver archiving, which may lead to poor management including storage of paper records across the Trust.	9	Possible	Moderate	9	6	03/05/2016	22/05/2017	Chronias, Andrew	Information Governance	Documentation	Corporate Services		Information Governance	Records Management Facilitator provides process and guidance for costed solutions. Archiving guidance published on the IG hub page	The process is not centralised or fully funded for services.	A business case was approved for high risk services records to be managed under the archiving consolidation project for 2015/16 Bi monthly risk report submitted to IGG to ensure that the risk is being managed effectively.. Clinical Records Archiving Project 2016-17 was approved by ELT	A further business case is yet to be approved for 2016/17
1616	There is no identified Trust leadership for clinical or corporate records which may lead to local amendment of record keeping standards and poor record keeping practices.	9	Possible	Moderate	9	6	03/05/2016	22/05/2017	Chronias, Andrew	Information Governance	Documentation	Corporate Services		Information Governance	Records Management Facilitator provides advice on records management code of practice, records protocols in relation to general records management processes.	The Records Management Facilitator is not clinical and therefore cannot advise on the clinical content.	Clinical records audits are carried out annually.	Not all records are managed through the Trust process

1738	There is currently no safe infrastructure or standardised approach to send and receive patient identifiable information via fax in the Merton Services at CLCH. This could lead to breaches information governance and financial penalties.	9	Unlikely	Moderate	6	3	06/09/2016	03/04/2017	Waskett, Rosie	Information Governance	IT Systems	South Division			eFax is covered in the mandatory IG training eFax page on the hub providing staff with guidance and faxing protocols (Do's and Don'ts) Transfer of Information and Safe Haven policy E-Fax user guide The Merton SPA have been authorised to use the multi-functional device for urgent communication to GP's in relation to referrals, this is limited to providing an NHS number, referral date, service referred to and additional date required. Scoping to identify which services have been sending faxes and identified the types and volumes of information they were sending- outcome was that no normal faxes are being sent Faxes are sent for rejected referrals only (SPA) Only NHS number is included as identifiable data in those faxes (SPA) The GP practice fax numbers have been programmed into the MFD as speed dials and the staff use the speed dials rather than typing in a whole number (SPA) The above speed dials have all been positively tested before use (SPA)	The SPA currently receive fax via goldfax (alternative to EFax), this will be replaced by dedicated EFax line for Merton when the service change sites (now April 17)	There have been no IG incidents related to faxes within the south division Copy of the email to SPA team	

1829	The Organisation currently does not have access to the Barnet Adastra clinical system due to technical changes within the Trust/Site. The system contains historical Walk In Centre patient records, the Information is held securely within the organisation but at present there is no way to retrieve these records. The risk to the organisation is that we are unable to conduct a retrospective review of records as and when required and respond to Subject Access Requests made by patients which is a requirement under the Data Protection Act. Failure to respond could lead to complaints being made to ICO and enforcement action being taken against the organisation.	12	Likely	Moderate	12	2	21/03/2017	31/05/2017	Chronias, Andrew	Information Governance	Documentation	Corporate Services	Corporate Services	Information Governance	An IT engagement form has been submitted to Capita IT to develop a read only front end which will allow access to the data. The data is secure as it is held by the Trust but there currently isn't a tool in place which allows us to access and pull off the data in a readable format.	There isn't a business continuity plan in place to minimise the impact to the business.	Bi monthly risk report submitted to IGG to monitor progress of the work being done to manage the risk. As the risk has a current score of 12, the risk will also be reported to PSRG on a monthly basis to ensure that the risk is being managed effectively.	Currently unable to provide a time frame of how long it will take for the development team to complete this piece of work.
IMT																	
919	Approximately 80% of the Trust's PC and laptop stock runs on Microsoft Windows XP. Technical support for XP will no longer be provided by Microsoft from 7/4/2014. Without support, any technical loopholes can be exploited maliciously and will not be patched by Microsoft. This puts the whole network at risk. Updating of Windows XP to Windows 7 is a major project which is not currently being	9	Unlikely	Moderate	6	3	02/10/2013	31/03/2017	Ahmed, Zakaria	Information Management and Technology	IT Systems	Corporate Services		IMT	Signed 12 month support contract with Microsoft for continued support and patching All new hardware is deployed with Windows 7 2,700 PC have been upgrades. 300 desktop PC's still outstanding due to software being used that is not compatible.	300 desk top PC still using XP due to software being used that is not compatible	Capita have confirmed that as the bulk of the PC have been updated they will gradually update the other as BAU. Some services unable to upgrade is not compatible with some clinical systems meaning some services will need to remain on XP Capita have confirmed that service desk will be able to answer XP issues	Project not due to be completed until the end of September 2015

	formally managed. The staff training implication is huge and timescales are tight.																	
1251	The growth specified in IT strategy results in inability to implement the changes in a controlled manner.	12	Unlikely	Major	8	6	23/02/2015	29/12/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	IM&T strategy group created and includes all divisions to ensure oversight from all services Governance framework in place including performance and Information steering group, performance and Information operation group Planned work programme of change created to minimalize disruption All change programmes include and will include change management training and support		All strategic projects will either have operational senior responsible owners or high levels of engagement with the business CLCH informatics groups, MT strategy group and CSOG have been created to ensure oversight and governance	Whilst groups have been created a bedding in period is needed to ensure compliance
1252	EMIS and TPP are unable to support the sharing of data and/or messaging between clinical systems. The impact of this will result in the Trust preventing Barnet users from accessing key data from GP systems and vice versa. This will also hinder the Trust from winning new business.	12	Possible	Moderate	9	4	23/02/2015	29/12/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	Close monitoring via the Interoperability Project Board and noted as dependency on Children's Go Live for SystmOne in June	EMIS and TPP unable to provide dates for community data interoperability. Delays in agreeing working agreements with TPP	TPP and EMIS released their formal agreement to work together to deliver Interoperability between their systems on 12/03/2015	Relationship with TPP can be problematic

1468	VoIP_Loss of Virgin Media WAN services to sites will result in total loss of data and VoIP telephony services.	12	Likely	Moderate	12	3	24/11/2015	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	- In the event of a telephony or complete network failure at a site, the VoIP system will allow users to migrate to different buildings and continue using the same telephone numbers. 12/04/2016: VOIP infrastructure operates through primary and secondary sites, allowing fail-over in case of loss of one data centre.	Services and sites will need to pre-plan where they would relocate staff to ensure at least a scaled down version of the service can continue in the event of a network outage at a CLCH site.	Review of service business continuity plans such that where continuity might be the use of email or telephony if either is lost, consider the use of mobile telephony and mobile working staff operating using 4G. In the case of call centre type services the use of the Cisco Finesse capability and arrangements with other sites to move a proportion of service staff there in the case of a major loss of site or network failure. The impact of VOIP has been discussed with services during both site and service engagement (each site and CBU Manager), this has been reinforced by the use of CLCH communication such as today at CLCH and the Hub which specifically covers resilience and business continuity planning http://thehub/ourteams/it/Pages/voip.aspx. There is more work to be done in this area which the resilience team are happy to support. A Local Area Network refresh as part of the Capita IM&T transformation will mean updated more robust switches for managing our Local networks, for which voice and data rely upon.	Resilience / CBU Managers to confirm business case plan.
1526	Microsoft no longer support Internet Explorer (IE) versions below 11, a number of national NHS systems will only function on older versions of IE. The lack of support means security release and critical patching will cease, placing the operation and security of old versions and systems that rely on them at risk	12	Likely	Moderate	12	6	15/01/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	IM&T Investigation of systems that are reliant upon old IE versions Any national or local systems where IE compliance is a concern to be escalated to HSCIC and system suppliers respectively	None within CLCH control 12/04/2016: Trust to determine ability to ability to upgrade IE version.	IM&T Investigation of systems that are reliant upon old IE versions Escalation to national body and system suppliers	Outcome of CLCH investigation not yet complete

1538	Interoperability: The Royal Free Acute Trust must provide timely assistance and information to CLCH in order for the Child Health 2 work stream to provide the predicted benefits to CLCH. The Royal Free incorporating Barnet Chase Farm hospital send CLCH the highest volume of paper notifications which will not be automated unless they agree to send us the information electronically.	6	Possible	Minor	6	1	05/02/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	Service Delivery	Corporate Services	Corporate Services	IMT	Regular, fully minuted Programme Board meetings; some capacity to escalate from SRO to CIO of Royal Free A conference call has been setup with Beth Foley for 03.06.16. Janet Lewis / Angela Cody have also been invited to participate in the call to support the building of a relationship and buying from the Royal Free.	Lack of capacity to compel Royal Free staff to act or respond in timely fashion. It is imperative that we are able to agree time bound next steps with the Royal Free. If the call is inconclusive or if it does not mobilise resources from the Royal Free then we will not be able to on board the Royal Free within the Programme's remaining timelines.		
1602	Mobile Working: Risk that large windows updates (released quarterly) may cause prolonged interruptions to the mobile devices while out in the field.	9	Possible	Moderate	9	6	20/04/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services		IMT	Need for investigation and advice to see how these necessary updates can be managed and controlled to minimise any disruption to users in the field. Technical analyst is developing methodology to push updates through to devices	Method of managing windows updates and how to update devices remotely and controlled to minimise any disruption to users in the field to be developed		
1603	Mobile Working: Risk that MW benefits are not delivered due to incorrect/limited use of SystmOne meaning staff do not change their ways of working as anticipated	12	Likely	Moderate	12	9	20/04/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	S1 process documents and quick reference guides. All teams directed to their local guides for data entry S1 team should keep the mobile working team abreast with any changes that are being made to work processes that clinicians use for data entry	Change management system for clinical systems	Business change for each division supporting service lines in correct use of clinical systems.	

1609	Mobile Working: There is a risk to achieving the MW financial benefits due to the benefits being calculated on the basis that staff are not currently working unpaid overtime. If this is not the case the time savings may be swallowed up by reducing unpaid hours worked rather than increasing patient contacts/wte.	16	Likely	Moderate	12	8	26/04/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	Financial Risk	Corporate Services			Monitoring of time above and beyond core work hours through the Day in the life of surveys	Day in life survey not a reliable indicator of amount of overtime worked, not all staff will have recorded details of work above and beyond their contracted work hours. Method of collecting this information not currently easily or reliably available	Service managers to implement system of monitoring time worked over contracted hours (unpaid)	Limited information available regarding outside of contracted hours working by staff available for staff groups
1631	Low prioritised requests for clinical system changes are not assigned development resource, impacting upon that services ability to update or increase functionality within their clinical system.	12	Likely	Moderate	12	8	13/05/2016	31/12/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services			CSOG process to review low prioritised requests, whereby 12 days was assigned out of the 50 days within the partnership agreement for clinical systems. Each low priority request would be reviewed every four months to ensure that it was still required, and whether the priority score had changed due to circumstances within the service.	Funding in the main. Trained clinical systems personnel for specific projects on occasion.	CSOG will have oversight of this, updating to IMT Strategy Group, who will report Minutes to ELT.	Breakdown of communication on hierarchical reportage.
1634	Health data is under increasing attack from information security and cyber security threats that mean it could be damaged, stolen or be unavailable.	12	Unlikely	Major	8	8	19/05/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT				

1718	If there is a delay for Merton staff to be provided with sim card's for their laptops, then there could be a significant impact on operational delivery (including visiting less patients due to staff need to come back to base, delays in out-coming visits etc.).	12	Rare	Moderate	3	3	08/08/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	Service Delivery	South Division	East Locality (Merton)		Issue has been escalated to Chief Information Officer 14/10/2016: CCN RAISED AND BEING WORKED THROUGH WITH STRATEGIC PARTNER FOR IMPLEMENTATION OF CLCH REMOTE ACCESS FOR MERTON CLINICIANS All staff to be issued with sim cards and laptops to be reconfigured	None currently identified		
1746	Interoperability: The Interoperability Programme requires a £2k revenue budget but no provision has been made.	4	Unlikely	Minor	4	1	16/09/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT				
1747	Interoperability: Consent to Share In: Open Issue from the Healthy Child Programme Pilot: where consent either has not been asked or has been set to decline. This prevents the input message being displayed in the journal. No error message is returned by S1 only a successfully updated record message. This issue is with TPP to correct and we are chasing a resolution.	4	Unlikely	Minor	4	1	16/09/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	Security	Corporate Services	Corporate Services	IMT				

1748	Interoperability: New Birth Notification: Is added to the waiting list for an appointment to be made but the entry is not named, a workaround will be put in place until fixed by TPP but we do not have a confirmed fix date from TPP this will require follow-up with TPP.	4	Unlikely	Minor	4	1	16/09/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT				
1749	Interoperability: The List Referral message from SystmOne returns a list of all open referrals, beginning with the oldest first, this issue came up during UAT and TPP agreed to send the data with the newest first. The purpose of the message is to return all open referrals for the mother / child, this is an issue because on SystmOne are a number of historic migration caseloads which date back to the RiO single instance and there are approx 40,000 historic open referrals and there is a risk that where a referral is already open for the mother on one of these historic caseloads, rather than creating a new referral the automation will (correctly) update the existing referral. The impact of this is that a new birth or antenatal could be missed.	4	Unlikely	Minor	4	1	16/09/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	Clinical Treatment	Corporate Services	Corporate Services	IMT				

1750	Interoperability: Upgrade of Rhapsody Integration Engine to V5.4 to V6.2: an upgrade of the Rhapsody test server was attempted on 26.08.16 it failed and it took over a week for the Capita team to restore the server. Mark Van-Ingen, Capita has advised that the backups at the data centre have not been configured correctly and that they are still trying to resolve these issues. Until the server backup and restore functionality is working another upgrade cannot be attempted and there is now no time remaining to undertake the upgrades because if issues arise they will not be proactively managed and resolved by the Interoperability Programme Team and there is a risk to the solution in place.	4	Unlikely	Minor	4	1	16/09/2016	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT				

1799	Risk: Risk that the Information Sharing Agreement between HCCG/CLCH will not be in place by close of EMIS Programme. Cause: HCCG are using the EMIS Programme as an opportunity to refresh their IG documentation with partners which severely delays this part of the process. A new version of the ISA has been created and the LMC are reviewing content and require GP Practice signature. Impact: EMIS system is ready for activation both sides. If delay then the activation/sign-off of ISA will need to be undertaken outside of the EMIS Programme. Additionally the forecast benefits will take longer to realise.	6	Almost Certain	Minor	10	5	27/01/2017	30/06/2017	Chronias, Andrew	Information Management and Technology	IT Systems	Corporate Services			Harrow CCG are working with the LMC to finalise the EMIS Direct Care Sharing Agreement. CLCH are ready with Quality Director David Bridger to assess the final version once received. SIRO/SRO Andrew Chronias is set as authorising signatory. Fred Gregory IG & Risk Manager is set to monitor and engage/move forward this work with HCCG. Capita IT - David Morley is ready with the BAU team to activate the sharing agreement for CLCH and to monitor progress of GP activation with CLCH/HCCG.	HCCG: current position comms to GPs. HCCG: Rather than one SPoC. to have multiple contacts that can progress work further.	Fred Gregory reporting to Andrew Chronias at CLCH Andrew Chronias/PSRG	NONE

1820	Edgware Community Hospital is the only site which still relies on Parsons Green Health Centre for access to the CLCH network, which is through a direct point to point link. This was a legacy arrangement – all sites used to link with Parsons Green in this way but they now access the network independently using the Virgin Media Business MPLS network, with the exception of ECH. In the past the shared N3 network at ECH (used by CLCH, Royal Free, BEH, NHSPS etc.) meant that even if the link to Parsons Green went down staff could still access SystmOne, however, now that the network has been changed to allow CLCH VoIP telephony at ECH this option no longer exists. If the network or the power at Parsons Green goes down ECH will lose all connectivity (including phones, SystmOne, eFax, email, shared folders, managed print, Wi-Fi etc.)	8	Likely	Minor	8	4	08/03/2017	30/06/2017	Ahmed, Zakaria	Information Management and Technology	IT Systems	Corporate Services	Corporate Services	IMT	LAN management is under Capita control for Capita to deliver the remedy plan.	Since VMB re-positioned the WAN link, the networks have been unable to migrate across from the existing link to the new link.	CAPITA IM&T WILL RESPOND TO ANY INCIDENTS AND RESOLVE INCIDENTS TO THE BEST OF THEIR ABILITY.	

857	BAF Risk: Failure to use mobile working technology to drive clinical and operational innovation does not results in the expected level of productivity gain.	12	Possible	Major	12	8	19/08/2013	30/06/2017	Fox, Mike	Information Management and Technology	Business Continuity	Corporate Services		Strategy and Performance	Change management resources are now in place including stronger operational leadership and buy in from services Business case for the Mobile working has been signed off Mobile working project team now in place System 1 now live in both Adults and children's Mobile working methodology reviewed as part of QIA process. Benefits realisation linked to KPI's and the ability to demonstrate productivity Methodology currently being assessed following roll out. Mobile working currently deploying, using agreed change methodology and support.	CBU managers may not recognise the methodology by which savings can be realised through productivity i.e. reduction in WTE or income generation	This is a significant transformation that is being managed as part of a complete work programme, both technical and organisational change. CLCH informatics groups and IMT strategy group have been created to ensure oversight and governance Training is being implemented and tested for quality and policy standards QIA process lead by chief nurse and medical director to ensure clinical quality delivery of services Transformation board monitors QIPP delivery	Not applicable
Medical Directorate																	

1606	Mobile Working: Risk of not being able to provide a safe level of care if Mobile Working project Whole Time Equivalent savings are implemented without an increase in productivity	12	Possible	Major	12	4	26/04/2016	31/05/2017	Medhurst, Dr Joanne	Medical Directorate	Clinical Treatment	Corporate Services			Change principles to support increase of productivity within services being communicated with all teams Quality Impact Assessment process devised to review if services are still providing safe standards of care before removal of WTE Service level discussions to look at options for removal of WTE within services against productivity savings External to project work being carried out on minimum safe levels of staffing, to be fed into MW project outcomes Ongoing monitoring of a range of KPIs to understand changes in productivity and quality of clinical care through the MW roll out Highlighting to all teams that other (potentially mobile enabled) productivity needs to be looked at as well as agreed benefits approach. Agreed benefits approach with DDO's	External to project work being carried out on minimum safe levels of staffing, to be fed into MW project outcomes Ongoing monitoring of a range of KPIs to understand Changes in productivity and quality of clinical care through the MW roll out	Transformation monthly updates on progress of MW project monthly update on project finances and projections of WTE savings expected. Survey following implementation of MW, Day in the life of reports Complaints and compliments sent to PALS regarding use of Mobile working as part of consultations MW KPIs monitored ongoing	
1780	Insufficient internal assurance that all clinical services are compliant with the latest medical devices awareness audit due to the audit schedule not being met. Internal audits provide evidence for CQC compliance Regulations 12 & 15 and are a part of the team's BAU and annual work programme.	9	Possible	Moderate	9	3	11/11/2016	28/04/2017	Johnstone, Clare	Medical Directorate	Medical Devices	Corporate Services			Medical Devices Policy Annual Work Programme 2016-17 Audit schedule Audit database Medical Devices & Product Selection Group (MDPSG)	Staffing resource due to long term sickness within the team Noncompliance of work programme due to other project priorities-supporting demobilisation and mobilisation of services	Reporting to MDPSG	
Reputational																		

1049	The new Minimum Data Set (MDS) for Early Years will not be fully functional by April 2014 due to a lack of access to external providers data and further incompatibility with NHSE scripts. This will prevent us from delivering a complete child health record as per NHSE requirements. Therefore clinicians will not have full information (as per MDS)relating to a child's health to enable further protection of vulnerable children. This will be reputational and financial as potentially part of new HV contract.	9	Possible	Moderate	9	6	28/01/2014	07/04/2017	Cody, Angela	Reputational	Safeguarding - Children	Children's Division	0-19 Services Barnet, Brent, Harrow and FNP Barnet	Child Health Information Hub	CHIS - MDS - Project plan, dedicated project manager project team established IT lead for interoperability Attending pan London networking events investigation into issues - monthly test runs of the MDS and analysis od the quality of the data Script for BCG and Hep B have been received, awaiting the LAC script by the end of September	full information sharing agreements and data sharing process for information within the MDS for external intervention e.g. New-born physical screen examination	Reviews across pan London re CHIS and MDS CHD project briefs/ performance reports	None identified
1255	Reputational risk arising from potential failure of Corporate Trustee to effectively manage charitable funds.	4	Rare	Major	4	4	24/02/2015	30/06/2017	MacDonald, Robert	Reputational	Administration	Corporate Services	Corporate Services	Finance	Subject to statutory annual external audit Internal governance arrangements in place to monitor charitable activities Charitable fund committee regularly reviews risk register Audit committee regularly reviews event and reputational risks Governance documentation now collated in single folder on shared drive		Comprehensive review undertaken to identify cause of delays in investment of funds, following a change of investment manager, undertaken. Recommendations approved 15.12.15 for implementation. Annual audit of charitable fund accounts by external auditor Internal audit of trust processes and controls in relation to financial management Charitable Funds committee meets 3-4 times per year on behalf of the Board to review activities of the charity.	None

1263	Vitamin D used by Health Visiting teams across Barnet borough, is not stored in a cabinet which meets the British Standards 2881 (1989) NHS Estates Building Note No 29 for medicines cabinets which is not compliant with CQC outcome 9 and therefore a reputational risk.	5	Possible	Negligible	3	1	16/03/2015	05/05/2017	Pearce, Sheila	Reputational	Medicines Management	Children's Division	0-19 Services Barnet, Brent, Harrow and FNP Barnet	Health Visiting	Medicines Management policy	British standards cabinet not being used in all bases No identified budget to purchase the British Standards 2881 (1989) NHS Estates Building Note No 29 for medicines cabinets	Alternate cabinets in use Divisional Integrated Quality & Performance Review monthly meetings Medicines Management annual audits/action plans
1368	Major donor to the charity / celebrity donor is later found to be disreputable (ref Lampard recommendations)which results in reputational damage	6	Unlikely	Moderate	6	4	06/08/2015	15/12/2017	Walbridge, Ms Jayne	Reputational	Policy	Corporate Services	Corporate Services	Finance	Guidance for acceptance and refusal of donations, updated in December 2015 and includes celebrity donors	It will be difficult to predict future risks in relation to celebrities or major donors Database of donors is not yet systematised	Guidance for staff includes criteria for refusal of donations Guidance includes the requirement for donations in excess of £5k to be acknowledged by the chairman Charitable Funds Committee receives regular reports, including donations

1401	Due to ongoing difficulties with generating reports from SystmOne there is a reputational risk to the Children's Division with a range of commissioners, and a potential financial risk.	16	Possible	Major	12	4	13/10/2015	31/05/2017	Chronias, Andrew	Reputational	IT Systems	Corporate Services	Corporate Services	IMT	Request for Tri-Borough S1 changes to accommodate required commissioner KPIs submitted and approved into development. S1 development by clinical systems team overseen by Clinical Systems Oversight Group. Weekly Reporting Working Group Monthly Performance & Information Steering Group Consolidated Detailed Report Tracker containing all regularly required reports internally and externally Divisional System one Reporting Meeting Performance, Information and Data Quality operational Group Monthly reporting timetable reporting development change control process consolidated and prioritised report development pipeline agreed with operational divisions		Required developments approved and overseen by the Clinical Systems Oversight Group Reports from Performance & Information Working Group to the P&I Steering Group. Data Quality Reports provided to divisions Completion of statutory and commissioner reporting deadlines reported to FRIC All Commissioner and Statutory reports are reviewed and signed off by business prior to submission Files of confirmation of submission of reports to external commissioners and regulators	files of external confirmations of submissions of commissioner and regulator reports

1414	Reputational risk to CLCH from the partnership with Capita - Services elsewhere in the Capita portfolio (perhaps unrelated to CLCH) attract negative publicity.	12	Possible	Minor	6	4	16/10/2015	15/03/2017	Stobie, Adrian	Reputational	Communication	Corporate Services	Corporate Services	Strategy and Performance	Open approach from Capita to highlighting as early as possible if a negative press story is likely to run - initiate regular communication channel between the partners' communications departments to ensure an agreed and prepared message is managed when necessary. Develop regular communication to all stakeholders to help develop capacity and confidence in the Trust's bidding teams. Ensure Director of PAP is sighted well in advance of a situation to allow him and the Partnership Director to work with Tom Stevenson in Communication in managing the message.	The Director of Partnerships and Procurement does not have direct links/access to Partner's communications team, so is reliant on the Trust's comms team/Partnership Director for information to be provided in a timely manner.	Since the creation of this risk, the Trust has won two major contracts (Merton and Harrow) where the Strategic Partnership has been instrumental in the success of the bid. This demonstrates that a negative reputational risk is now lower than previously anticipated and as such the risk to the Trust is now lower.	A risk materialised on 120416 in regard to a separate contract Capita runs for the DWP and the Chanel 4 Dispatches programme. This was handled in accordance with the agreed procedures. This risk has materialised in the last month - Telegraph expose article Dec 2015 on practices at Team 24, a subsidiary of Capita Healthcare Services. http://www.telegraph.co.uk/news/nhs/12064456/Driven-by-money-the-1m-biller-for-NHS-nurses.html The risk materialized on 5th June in relation to difficulties with the London Mayor Election at the London Borough of Barnet and the relationship they have with a large Capita strategic partnership. It also materialized on 12th May with an article in the HSJ in relation to criticism of Capita running a large NHS contract for primary care services. Mini ELT and Tom Stevenson was fully briefed in relation to both events. The risk materialized on 5th June in relation to difficulties with the London Mayor Election at the London Borough of Barnet and the relationship they have with a large Capita strategic partnership. It also materialized on 12th May with an article in the HSJ in relation to criticism of Capita running a large NHS contract for primary care services. Mini ELT and Tom Stevenson was fully briefed in relation to both events.
1507	Failure to comply with investment policy results in reputational damage.	9	Unlikely	Moderate	6	6	15/12/2015	30/06/2017	MacDonald, Robert	Reputational	Financial Risk	Corporate Services			Investment and reserves policy in place, including statement in relation to tobacco and derivatives Policy reviewed in July 2016, note added that CLCH does not make any direct investments; all investments are made through our investment manager (Cazenove, whose policy is that there are no restrictions on tobacco per se, but that investments are only made in other funds - not companies).		Regular reports are provided by Cazenove and shared with committee members (monthly) by email.	

1508	Failure to invest charitable funds ethically leads to reputational damage	8	Unlikely	Major	8	4	15/12/2015	30/06/2017	MacDonald, Robert	Reputational	Policy	Corporate Services			Ethical policy reviewed at meeting of 04.07.16 Ethical policy states the following "direct investments in tobacco companies and derivatives are not permitted"	While the Charity's investment manager does not directly invest in tobacco companies and derivatives, investments are made into funds rather than companies and it is known that a small percentage of these funds include income from tobacco	Investment manager attends the Committee at least annually Cazenove provide regular and timely reports in relation to the market and the investment portfolio	
1529	Information published online about Trust services including recent mobilisations and demobilisations is not accurate, leading to confusion, poor patient experience and/or missed business opportunities.	8	Likely	Minor	8	2	01/02/2016	31/07/2017	Stevenson, Mr Tom	Reputational	Data Quality	Corporate Services	Corporate Services	Communications Team	Full content review service pages on website underway (Nov2016) Comms team reviewed services page layouts and contacting all services in Aug 16 to collect updates Initial Merton & Harrow service information added to public website including pages for referrers New comms model for supporting divisions has identified leads contacting teams for updates NHS Choices service reviews/comments received by communications teams and forwarded to appropriate service/PALS to respond	Google pages allow all public to submit edits without CLCH approval step Limited capacity to manage multiple data sources online NHS Choices data due for review and updates across all services	Communications team KPI for 16/17 to review and update minimum of 10 web pages per month	

1530	Information published in print about Trust services is not accurate or not available in alternative formats. Leads to confusion/poor patient experience or challenge against Accessible Information Standards (applies from April 2016)	8	Likely	Minor	8	2	01/02/2016	31/05/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Updates to patient information planned as part of Merton and Harrow mobilisation Project for implementing Accessible Information Standard across Trust will address alternative format information Accessible Information Standard action plan developed and comms work underway New comms model for supporting divisions will help identify changes and process updates quickly Whole trust audit of patient information being planned by communications, initial data gathering started Confirmed contract with existing translation services cover production of all relevant accessible format	Need to update action plan for audit and updates to patient information across existing CLCH services Need to implement functionality for recording AIS needs across all clinical systems	Initial information on AIS published on Hub and external website for 31 Mar 2016	
1531	Teams across Trust do not take responsibility for relevant sections on staff intranet, leading to limited or inaccurate information available to others.	12	Possible	Minor	6	4	01/02/2016	31/07/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Content manager / intranet user group meeting set up to develop skills and reiterate need to update pages IT removing access to old Hub pages on request from communications forcing teams to move content to new site Links back to old intranet removed from new site at end of July 16 Divisional lead responsibilities assigned to comms managers and officers Identified communications manager leading on migration and chasing teams to support Content manager training sessions delivered and 1-2-1 support provided to team content managers by comms team	All teams have significant workloads and Hub updates difficult to prioritise	Comms managers have divisional lead roles and are actively contacting teams for Hub and web updates Hub development is key objective in individual communication manager's work plan Progress on Hub migration is a KPI for communications within corporate performance reports Old Hub permissions being switched off so no risk of team continuing to edit old sections	

1532	CLCH brand mismatch with current geographical scale affects commissioner and staff engagement leading to lost business and/or poor engagement.	9	Possible	Moderate	9	2	01/02/2016	30/06/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	ELT & Board agreement to proceed with rebrand exercise from October 2016 Strong internal engagement in October 2016 on developing ideas for renaming ELT paper on options being developed for December 2016	NHS England brand policy in draft but yet to be finalised - expected end July 16 Budget for project flagged but would require approval as in year cost pressure DH approval to rename will be required - 2 month min lead in time from submission DH & NHSE approval will be subject to seeing support from key stakeholders including NHS England London Region	Project plan drafted by Comms team Decision to progress will be made by ELT and implementation reported back through ELT ELT and NED representation in project is planned for engagement phase in October	
1533	Patient information for Merton and Harrow services continues to display old provider logo or inaccurate information about services.	9	Likely	Minor	8	2	01/02/2016	01/06/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Template and guide for patient information developed and circulated to Merton staff Main service directory for Merton updated and published to CLCH website Contacts made with LNW comms team in Harrow to supply existing materials Agreement with RMH to continue using SMCS material provided content and contact details remain accurate Wider Trust branding review later in 2016 will pick up full update of Merton & Harrow materials	Full list of materials to be reviewed by each team against guidance now services have transferred. Costs of reprints to be approved at service level	Board approve plan for rebranding will cover all areas and pick up replacing old SMCS and LNW branding	
1714	Due to difficulty in recruiting to the band 7 Senior Infection Prevention Nurse post, there is a risk that the Infection Prevention Team will be unable to deliver the infection prevention work and audit programme, or provide a consistent and effective level of support to all CLCH clinical services to maintain assurance that the organisation is compliant with the Hygiene Code.	9	Possible	Moderate	9	3	05/08/2016	28/04/2017	Johnstone, Clare	Reputational	Infection Prevention	Corporate Services	Corporate Services	Infection Prevention	Work and audit programme in place	Insufficient staff to deliver the work and audit programme	Band 7 IPN job out to advert Progress against the work and audit programme reported to the quarterly Infection Prevention Group	Difficulty to recruit via NHS Jobs

1728	Insufficient numbers of staff engage in rebranding work.	9	Rare	Negligible	1	2	18/08/2016	01/06/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Engagement activities planned across multiple sites and channels. Significant publicity of the rebranding project planned Main period of engagement outside of holiday periods		140 staff attended open staff meetings in October, 300+ responses to online survey and 90+ suggestions for renaming submitted through Hub	
1729	NHS England or Department of Health do not approve the Trust's preferred option for a new name	9	Possible	Moderate	9	3	18/08/2016	31/08/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Pre-engagement with the identity team on requirements Clarity on requirements outlined and repeated throughout the ideas gathering stage Shortlisting of options against requirements Finalising a shortlist of 2-3 options any of which the Board would be happy with Introduction of visual identity would progress even if name change was rejected meaning spend on design changes still relevant			
1730	Influential stakeholders object to our preferred option for renaming the Trust.	9	Possible	Moderate	9	3	18/08/2016	31/08/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Plans in place to inform all relevant stakeholders of the project and our rationale Engaging NHS England identity team on impact of any objection to the Trust's preferred new name Clear rationale presented in rename request to NHSE/DH to counter any objection/lack of support		All key stakeholders written to with initial plans. No negative responses received. Two positive notes of support to change name.	
1731	Public criticism of wasting money on renaming the Trust and branding.	6	Possible	Minor	6	2	18/08/2016	31/08/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	A proportionate budget and limiting use of external support to work we cannot do ourselves Robust lines developed on our rationale			

1732	Phased implementation of renaming and rebranding Trust leaves double branding in place across materials causing confusion for staff, patients and stakeholders.	9	Possible	Moderate	9	2	18/08/2016	01/12/2017	Stevenson, Mr Tom	Reputational	Communication	Corporate Services	Corporate Services	Communications Team	Develop an effective prioritised list for replacing materials to minimise impact of double branding Clarify rationale for phasing to all staff and relevant stakeholders Ensure phased implementation is delivered on time to minimise length of double branding			
1811	Unable to deliver full service specification as per contract due to lack of agreed SLA for Consultant support.	9	Possible	Moderate	9	4	20/02/2017	28/04/2017	Allain, Jackie	Reputational	Clinical Treatment	North Division	Harrow Nursing, Intermediate Care and Podiatry					
1812	There is a risk that the required Estate to deliver the service will not be agreed prior to mobilisation.	8	Likely	Minor	8	2	20/02/2017	28/04/2017	Allain, Jackie	Reputational	Estates and Site Management	North Division	Harrow Nursing, Intermediate Care and Podiatry		Review of all current available Estate by CBU Manager and Project Lead.			
Security																		
441	Lone Workers, particularly in the Community, vulnerable to Violence and Abuse.	15	Possible	Major	12	10	07/02/2012	30/04/2017	Faulds, Ron	Security	Operational Risk	Corporate Services		Resilience and Compliance Team	Buddy and Diary System Lone Worker Policy Violence and Aggression Policy Access to the LSMS for advice and support	Inability to summon assistance in the event of adverse incident	NHS Protect annual statistics Audit of Lone Worker Policy conducted every two years Staff Survey - Reflects staff confidence in the workplace and access to LSMS Currently Level 1 Incident Investigation and Monitoring	

Workforce																		
1175	If CLCH continue to have problems recruiting Band 5 and 6 School Nurses in Hounslow and Richmond, as well as retaining School Nurses currently employed by the Trust, alongside the agency cap; then the Trust will not be able to deliver a comprehensive service to schools across all boroughs including safeguarding caseloads which will impact on clinical care, staff morale and the reputation of the service and Trust.	12	Possible	Moderate	9	6	22/08/2014	30/06/2017	Pearce, Sheila	Workforce	Business Continuity	Children's Division		School Nursing	Monthly CBU Level Integrated Quality & Performance Review meetings Divisional Management team meeting- monthly Monthly workforce reports provided to each CBU	None identified	Divisional report into Trust wide Recruitment and retention Summit - Monthly.	None identified
1636	Barnet Occupational Therapy Team has a vacancy of 2.5 wte Band 7 staff and 2.0 Band 6 staff. The impact is annual activity plan will not be met in the short term. Ongoing recruitment plan in place for both substantive and Bank/Agency staff. There is a clinical risk that children are not receiving their treatments in a timely manner and a reputational risk that KPI's are not achieved.	15	Possible	Moderate	9	6	23/05/2016	30/06/2017	Welch, Elizabeth	Workforce	Clinical Treatment	Children's Division	Complex Children	Specialist Therapies	Locum OT Band 6 employed from 1 April 2016 International Recruitment Underway Substantive adverts active for both Band 6 & Band 7 OT Weekly CV's vetted from Agencies Monitored at Local Therapy Team Meetings and CBU Performance Review Meeting	None identified	Minutes from Team and CBU PR meetings JD & Person Spec approved via ACF panel	
1655	Our retention rates mean that although we recruit to posts the high turnover requires us to constantly re-recruit.	9	Possible	Moderate	9	4	15/06/2016	30/06/2017	Boynton, Emily	Workforce	Staffing Levels	Corporate Services			Monthly monitoring of voluntary turnover in workforce reports Monthly monitoring of starters and leavers by divisions Reasons for leaving and exit interviews & questionnaires monitored by HR	Develop and implement a people strategy to support existing staff feeling valued and motivated.	A Workforce Programme Board will review risks every month as part of its status report submission to the Trust Board	

1658	Resistance from staff and staff-side to changes in the protected pay policy terms and conditions impacts negatively on employee relations and QIPP programme	4	Likely	Negligible	4	4	15/06/2016	30/06/2017	Boynton, Emily	Workforce	Policy	Corporate Services				Activity taken to find posts within CLCH currently matching employees original bands on pay protection with a view to supporting them to apply for these posts	A Workforce Programme Board will review risks every month as part of its status report submission to the Trust Board	
1668	RE: Allocate. If staff don't fully utilise the e-Rostering tool the project roll-out timeline and its benefits realisation are at risk.	6	Unlikely	Moderate	6	3	17/06/2016	30/06/2017	Boynton, Emily	Workforce	Financial Risk	Corporate Services						
1676	Audit by capita of DBS compliance with 5 year renewals suggests a level of non-compliance prior to service transfer and continuing, however the data quality and reporting needs further review. DBS checks on appointment are complete. There is no national requirement on renewals only on appointment but any suggestion of non-compliance may impact our reputation particularly in areas like children's services. Harrow staff do not appear to have had any renewals of DBS checks.	6	Unlikely	Moderate	6	2	20/06/2016	30/06/2017	Boynton, Emily	Workforce	Documentation	Corporate Services		Human Resources	Criminal offences in employment committed by our staff are likely to be reported to us by staff or the police DBS renewals are not a national requirement unlike checks on appointment DBS checks are only one way of ensuring we have the right staff working for us, supervision, appraisal, training, observation, registration are all more useful tools	Action plan agreed with capita to resolve reporting, policy and backlog of renewals Communication plan to staff to explain approach and need to move to 3 yearly renewals Discuss with DDOs impact on clinical services of processing an increased level of renewals on operational services	A new monthly report focusing on workforce compliance to be developed with capita	It is possible that a criminal offence or DBS issue may have occurred during employment which we are unaware of
1715	As part of the probation audit 5/17 staff files were identified for review that could not be found on TRAC. There is a risk that the staff concerned may not have had all the appropriate pre-employment checks completed as these cannot be evidenced.	9	Possible	Moderate	9	4	05/08/2016	30/06/2017	Boynton, Emily	Workforce	Data Quality	Corporate Services			Clear policy outlining what employment checks are required before an employee starts work with the trust Contract with Capita for recruitment/HR admin expects full compliance with employment checks policy Audit of starters and leavers process undertaken by external audit	Legacy issue to be addressed of paper employee records in CLCH and electronic records held by capita Have not been able to find relevant employee records	Progress will need to be reported back to audit committee and workforce committee	

1725	Risk of not meeting the Public sector target to recruit 44 apprenticeships by Mar 2017. Potential to impact on reputation of the Trust.	9	Possible	Moderate	9	6	12/08/2016	28/02/2017	Pinnock, Marcia	Workforce	Staffing Levels	Corporate Services			Apprenticeship strategy Apprenticeship subgroup	Development of strategy in progress Implementation plan in progress	subgroup will report regularly to Workforce Board	
1771	That the recruitment process from offer to start date, driven partly by the need to complete employment checks such as DBS to comply with CQC/NHS standards, takes too long resulting in higher than necessary vacancy rates and agency staffing use.	12	Likely	Moderate	12	6	21/10/2016	30/06/2017	Boynton, Emily	Workforce	Administration	Corporate Services	Corporate Services	Human Resources	New starters task and finish group set up to improve the new starter experience and process Considering our approach to the use of risk assessments as a trust in relation to DBS checks NHS Lobbying to speed up the DBS process as it has slowed nationally	There are policies in relation to employment checks, linked to national guidance and a rehabilitation of offenders but not a single safer staffing or recruitment policy	Vacancy rate and agency spending should reduce	New KPI needed to monitor time from offer to start date
1801	Data quality risk in relation to ESR following imports of data through TUPE transfers means professional registration renewals and DBS renewal processes may not be effective for a minority of staff	8	Unlikely	Minor	4	4	01/02/2017	01/05/2017	Boynton, Emily	Workforce	Data Quality	Corporate Services			Individuals are personally responsible for maintaining professional registration Checks are made at recruitment that the individual holds professional registration	Once an employee is set up in ESR especially through TUPE transfer a data quality check needs to take place		
1828	Increase risk of harm to staff due to recent increase in reported incidents of violence and aggression perpetrated by patients, relatives and carers in patient's homes towards CLCH staff. These incidents have included verbal and physical threats and aggression.	9	Possible	Moderate	9	4	20/03/2017	31/05/2017	Cupid, Wendy	Workforce	Violence & Abuse	North Division	Community Nursing Services - Barnet		Lone working policy Lone working devices Risk assessment	some staff display a lack of understanding of these risk by not carrying their lone worker devices		
816	Agenda for Change Annex W, "linking pay and appraisal ratings" implementation fails to achieve desired outcomes and does not support corporate objectives.	9	Unlikely	Moderate	6	6	07/08/2013	01/05/2017	Boynton, Emily	Workforce	Strategic Risk	Corporate Services		Human Resources	National Agenda for Change agreement Current Trust PADR and pay procedural guidance Joint Staff Consultative arrangements and working groups	Uncertainty in effectiveness of PADR system and appraisal guidance needs to be amended		

847	Community Nursing staff in Barnet are not accessing clinical supervision. This will mean they are not supported routinely and do not access a supervisor for professional development. Staff have limited time for CS and also there are a lack of supervisors within Barnet.	15	Unlikely	Moderate	6	4	16/08/2013	31/05/2017	Cupid, Wendy	Workforce	Staffing Levels	North Division	Community Nursing Services - Barnet	District Nursing	Dedicated clinical supervision lead Locality managers in post have provision for individual/group supervision with North division ADQ Weekly band 7 meetings Clinical Supervision Policy All staff have record of the clinical training they have completed (inc. mandatory training) Appraisals for all staff Group clinical supervision sessions yet to be set up for 2015 and staff have been invited		ongoing monitoring of clinical competencies./clinical outcomes and learning needs led by the clinical educator Nurse within the service. Minutes of band 7 meetings Trust KPI on appraisal completion Mandatory training records	Compliance against clinical supervision policy
295	Poor or inadequate IM&T skills threaten IM&T benefits realisation, including accurate activity recording with consequences for Finance	12	Possible	Moderate	9	8	20/07/2010	31/05/2017	Daley, Marcia	Workforce	Corporate Risk	Corporate Services		Learning Team	IT have developed a competency profile for a broad range of posts	IM&T Training no longer offered	Staff Appraisals will highlight training needs	Appraisal process does not focus on IT skills and weakness may not be picked up
817	Leadership styles not consistent with Trust values and managers/team leaders not delivering the required standard of management competence affect both morale and sustained delivery of corporate and strategic objectives, impacting on delivery of services and relationships with stakeholders.	12	Possible	Minor	6	6	08/08/2013	01/05/2017	Boynton, Emily	Workforce	Corporate Risk	Corporate Services		Human Resources	Trust HR policies DDO, CBU Development Programmes & Team Leader Programme Personal Appraisal and Development Review process	CBU Programme starts 8.14 Team Leaders Programme has been delayed. CBU Programme Completed. Evaluation due May 2015. Team Leader Programme due to commence July 2015	Reports to Board on Staff Survey results Reports to workforce group	Evaluation of programme to be considered by ELT

750	Effective management of individual performance will not achieved unless all staff, as a minimum, have an annual appraisal, agree clear objectives and a personal development plan to ensure they are supported to obtain the skills and knowledge required to achieve their objectives.	12	Likely	Moderate	12	6	04/07/2013	30/06/2017	Boynton, Emily	Workforce	Strategic Risk	Corporate Services		Human Resources	Electronic reporting tool Training for staff and managers Communications and reminders with Associate Directors/ Directors and Senior Managers Issue raised with the Executive team Close monitoring by the OD team Quality strategy Trust KPI Included in ClickView dashboard	No consequences for managers or employees for not completing performance appraisals	Staff not reporting 100% appraisal Evaluation of training very good Electronic system not reporting 100% achievement	Second internal audit not yet undertaken in regard to quality of performance appraisals
747	The probationary period policy is not being worked through consistently with staff who join CLCH. This could result in staff being confirmed in post whose skills and aptitudes are below the levels required for effective performance and adversely impacting on quality and safety of clinical services.	16	Possible	Moderate	9	4	03/07/2013	30/06/2017	Boynton, Emily	Workforce	Corporate Risk	Corporate Services		Human Resources	Offer letter to new appointees offers post on the condition of successful completion of a probationary period. Managers of new appointees are sent a copy of the probationary period policy to work through with new appointees. Reports run by workforce information team for hr transformation team (HR Advisers) who send managers reminders that mid-stage review meetings are due. Reports run by workforce information team for HR Transformation team (HR Advisers) who send managers reminders that end stage review meetings are due. Probationary period policy makes cross reference to induction, PADR and clinical supervision arrangements so that work and evidence can be used to meet a range of Trust requirements. Robust recruitment process is in place - not sufficiently taken into consideration in assessment of initial rating. Objectives are set for new starters in month 2 of the Probationary Period and reviewed in month 5. This includes a performance rating recorded on the system.	HR Advisers from the HR Transformation Team have limited capacity for chasing up managers for completed mid and end stage review reports.	Report on probationary period provided to Audit Committee with management action plan	