Report to:	Trust Board (Public)	**Agenda item:**	14
Date of Meeting:	7 February 2019		

Report Title:	Board Assurance Framework and Corporate Risk Register			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	- Revised Board Assurance Framework (v8.1 Jan 2019) - Corporate Risk Register Summary (8v2 January 2019) - Corporate Risk Register (v2 Jan 2019)			

Recommendation:
The Board are asked to consider and approve the revised Board Assurance Framework.

Executive Summary:
Background The Board Assurance Framework (BAF) provides the Trust Board with a means for satisfying itself that its responsibilities are being discharged effectively and objectives delivered. This informs the Annual Governance Statement and annual cycle of business. **Process:** The BAF format was adopted by the Board in December 2017 and is presented to the Board at each of its public meetings, together with the Corporate Risk Register (CRR), to ensure that the risks described are the most valid and the document remains fit for purpose following review of assigned sections through each of the Board's Committees: • Local Services : Finance & Performance Committee • Specialist Services : Finance & Performance Committee • Innovation: Clinical Governance Committee • Care : Clinical Governance Committee • People : Workforce Committee • Resources : Finance and Performance Committee • Strategic objectives: Strategy Committee In addition the Trust Management Committee reviews the complete BAF and CRR as part

of this bi-monthly process.

The aims of the revised BAF are to:

- Ensure there is clear alignment between the Trust's Strategy, BAF and CRR
- Enable the Board to be able to clearly see progress / deterioration of risks on the CRR and where required request further assurance / deep dive
- Support the updating of actions against gaps in one place

The BAF:

The BAF has been revised and updated to include items raised through the Board Committees.

Supporting Documentation:

- The Corporate Risk Register (CRR) is presented alongside the BAF for review
- The Corporate Risk Register Summary supporting the CRR, tracks the risk over previous months, detailing the date of addition to the risk register and Lead Executive. Updates can also be requested and tracked through this summary sheet

Review of Risks:

It is clear from the 'Strategic Priorities – Risk Overview' summary that our highest risk areas are:

- Local services: continuing challenges with ED performance and gastroenterology service provision.
- People: continuing challenges in recruitment and retention, particularly Registered Nurses and excessive agency use.
- Resources: ability to achieve the financial plan and deliver financially sustainable services.

New Risks

The following risks have been added to the CRR following committee review:

- 5607 - Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing (Care): L3xC4 = 12
- 5704 – The inability to provide a full gastroenterology service due to a lack of medical staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed (Care): L4xC4 =16
- 5705 – Impact on the daily running of the hospital as a result of Great Britain's exit from the European Union The consequence is that the resources (stocks and staff) could be depleted affecting service provision. (Resources): L3xC4 = 12
- 5706 – Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment (Care): L3xC4 = 12

Risks removed

- 5611 - Impact of long running major incident to delivery of strategic work streams (Care)
- 5379 - Risk to perioperative safety due to increased number of never events reported in 17/18 (Care/People)

- 5291 - Potential for bleep failure (Care)
- 5421 - Incident reports – clinician requested timescales (Care)
- 5193 - Aging pharmacy robotic equipment (Resources)
- 5261 - Rechecking system inadequate to maintain current DBS recheck requirement (People)
- 5340 - ESR portal access (People)
- 5436 - Quality improvement methodology funding (Innovation)
- 5305 - Consitutional performance standards may not be met as result of increased demand or decreased capacity (Local)
- 5516 - Increase in emergency attendances (Care)

Risks with decreased scores

- 5436 - Funding for quality improvement (QI) methodology (12 to 6)
- 5577 - Risk to patient safety due to overcrowding in ED (15 to 12)
- 5397 - Due to inability to recruit enough nurses a decision has been taken not to open the additional medical beds (16 to 12)
- 5396 - Potential non delivery of CQUIN schemes (Resources): 12 to 9
- 3322 - Genetics National Reconfiguration (Specialist): 12 to 9
- 5364 - Failure to achieve ward nursing establishment (People): 20 to 16

Risks with an increased score

- 4808 - Vascular surgery provision (Specialist): 9 to 12

Review of gaps in control:

Through the review process, the following new gaps in control have been identified:

5704: Gastroenterology Service Provision

- Unsuccessful recruitment of new staff to the Gastroenterology team despite an ongoing recruitment campaign.
- National shortage of gastroenterologists.
- Currently unable to meet full demand for bowel screening and bowel scope programmes.

5705: EU Exit Planning

- Uncertainty of the national outcome.
- Not all risk assessments have been completed.

5706: Interventional Radiology

- University Hospital of Southampton are unable to provide a 5 day a week service and are unable to provide a service on days that align to visiting vascular surgeons and are unable to guarantee provision of the service going forward.

Next Stages:

- A Board workshop was held on 17 January 2019 with the purpose of identifying any internal or external risks to achievement of the strategic objectives. These risks will now be reviewed with the aim to identify controls, assurance mechanisms and any identified actions to address gaps in either control or assurance.
- A revised BAF format to be presented at the April Board meeting.
- Risks on the Corporate Risk Register will continue to be reviewed by the Executive Leads to ensure they are representative of the actual current risk and that actions are up

to date

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Salisbury
NHS Foundation Trust

Board Assurance Framework
2018/19

V8.1 as of 01/02/2019

Trust Vision: An Outstanding Experience for Every Patient

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/ systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Internal Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2: semi-independent Assurance** For example – Non-Executive Director walk arounds, Internal Audits **Level 3 External Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

Risk Matrix Score Key

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

Strategic Priorities – Risk Overview

	Overall risk score
Local Services We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.	
Specialist Services We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.	
Innovation We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	
Care We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	
People We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	
Resources We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	

Strategic Priority:

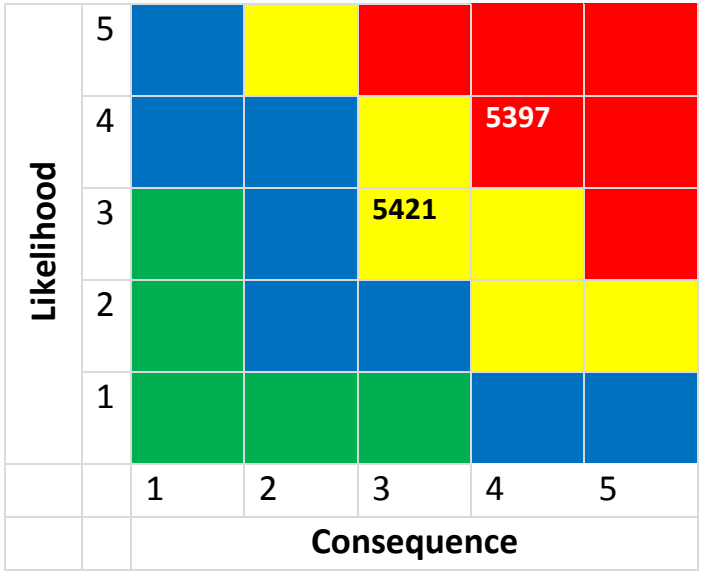
> **Local Services –** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance & Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Frail Elderly** - Development of an integrated frail elderly service	COO	April 2019	
2. **Emergency Care** - Implement new systems to manage the flow of emergency patients	COO	Dec 2018	
3. **Delayed Discharge** - Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO	April 2019	
4. **Access** – Improving access to core services to support prompt, responsive care	COO	Oct 2018	

Corporate Risk Register Principal Linked Risks



5421 – Incident reports – clinician requested timescales

5397 - inability to recruit enough nurse a decision has been taken not to open the additional medical beds

Key Controls	Assurance on Controls
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Ward reconfiguration governance structure • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wilts Health and Care	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group

Key Headlines - Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Development of an integrated frail elderly service	• Performance against quality metrics including increased number of discharges within 48 hours • Workshop to develop pathways for older people across the health economy has been agreed; actions being taken forward • Patient ward moves reduced (Getting the patient to the right place, first time) • Locality model for elderly pathways now fully implemented	• Unsuccessful recruitment of acute physicians	Interview with aim to appoint 19 November 18 Ensure locum in post on-going Re-advertise early 2019	Nov 18	On-going advert out for vacancies. Jan 19 update: Recent recruitment unsuccessful. Plan to re-advertise early 19. Locum in post at most times. Requesting second locum for Q4 period.
		• Agreeing pathways from ED/AMU to frailty	Fortnightly huddles with each medical ward to embed learning and monitor patient flow measures	June 18	Implemented and on-going
			Recovery Action Plan to be presented to COO - AH	Sept 18	Complete

		• Inability to create capacity between AMU and Durrington to support the frail elderly pathway	Address improvements through Patient Flow workstream Improvement actions to be embedded through the daily operational meetings - AH	July 2018 Nov 2018	Complete Work on-going. Next step is creating early community capacity to discharge patients
		• Records of patient moves not consistently kept up to date	Systems and processes to be addressed through Patient Flow workstream (delivery linked to recruitment plan)	Q3 18/19	Linked to action below
			Audit July moves between 8 pm and 6 am - AH	~~Oct 18~~ ~~Dec 18~~ 30/04/19	Audit completed and demonstrated that bed moves not accurate on Lorenzo. Being addressed with wards as part of SAFER. Revised deadline 30/04/19
		• Lack of single community bed base to ensure seamless pathway	Address through EDLBD: Weekly senior leaders meeting reviewing community capacity	Oct 18	Complete
		• Lack of community pathways to facilitate discharge	Monthly Strategic Frailty meetings established (Acute, Community)	Sept 18	Complete
			STP launch (Older Persons)	Sept 18	Complete
			SFT Operational working group meetings established (bi-monthly)	Oct 18	Complete

			Process map patient pathway (internal, external partners including outreach clinics)	Oct 18	Complete
			Research National Older persons work and present findings to Strategic Group	Oct 18	Complete
			Comprehensive Geriatrician Assessment (CGA) forms reviewed and revised (Internal/External)	Dec 18	A working group has been set up to review the existing version used in the Trust, and those available outside of the Trust, including local partners. The group are working to align community and acute forms to reduce duplication.

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
2. Implement new systems to manage the flow of emergency patients	• Performance against national standards and internal quality metrics (improving length of stay and flow of patients) • Positive ED quality metrics • Good progress with new build, project on track - Ophthalmology, AMU and short stay surgery units open; Pembroke move completed May 2018 • Active use of escalation process over winter period • Escalation of ambulance handover delays has improved this issue	• Reliance on agency staff effecting ability to embed new ways of working	Trust wide recruitment plan –PH	~~Q3 18/19~~ 31/03/2019	Revised deadline as action aligned to operating plan
		• Accurate data entry at ward levels	SFT IT team working with supplier to develop the two way link – AH/LA	July 18	Complete
		• Medicine length of stay greater than benchmark • Additional medical beds not opening in Q1	Improvements in patient flow, including length of stay reductions, being managed through a revised action plan with agreed KPIs and via a weekly PMB - AH	Nov 18	Work on-going. Next step is community discharge action plan to be delivered through the ED Local Delivery Board
		• Inability to fill ED navigator role	Escalate workforce requirement with ambulance service – AH	Oct 18	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
3. Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	• Clarity on the number of non DTOC delays being reported • Early triggers in place to alert other providers when numbers of delays are increasing • Trust membership of Joint Commissioning Board • Trust membership of Health and Wellbeing Board • Trust representation on the Integration and Better Care Fund group	• Community/voluntary sector funding and capacity	Being addressed through Council CQC action plan and ED Local Delivery Board - AH	Dec 18	Meeting with CCG and CSU 14/01/2019 re progress on capacity mapping
		• Staff availability to identify and develop opportunities to improve pathways and discharge	Local Workforce Action Board (LWAB) system wide workforce recruitment plan - PH	Q4 18/19	
		• Inability of the health system to respond to increases in demand	Regular senior decision maker meetings taking place across the health economy to address actions - AH	Sept 18	Complete
			In-depth review of all delayed discharges across south Wiltshire – AH	June 18	Complete
			NHSE escalation framework being followed due to lack of community capacity including daily gold calls now including CEO level – AH	Oct 18	Complete and on-going
			Development of Trust plan should community capacity not be delivered - AH	~~Oct 18~~ Nov 18	Complete
		• Community capacity not aligned to need	STP capacity and demand modelling across the system - AH	Oct 18	Meeting with CCG 14/01/19
		• Capacity within health system to step up discharge support as part of a major incident response	System-wide weekly meeting to agree actions to reduce the number of stranded patients – AH	Ongoing	In place and on-going

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
4. Improving access to core services to support prompt, responsive care	• Delivering national access standard • Reports indicate current performance and waiting list now delivering • RTT waiting list has stabilised • Clarity obtained as to what capacity is required to clear backlogs	• Accurate capacity and demand modelling to inform consultant job planning	Operational demand and capacity mapping – AH	~~Oct 18~~ March 19	Delayed. Deadline revised
			Job planning process and job planning review framework set up and managed through PMB – PH	Q3 18/19	Complete Process established
		• Follow up waiting list still being validated	Plastics and Urology follow up waiting list being administratively validated up to 2017 –AH	July 18	Complete
			All follow-up waiting lists being administratively validated up to 2018 - AH	Dec 18	Complete
		• Additional short term capacity required to clear backlogs – concern about affordability and whether deliverable delivered	Capacity and demand modelling is addressing backlog- AH	Sept 18	Complete
		• Inability to increase capacity to clear backlogs in a timely way (may be affected by financial position)	Capacity and demand modelling to identify gap to be addressed -AH	Sept 18	Targets currently being delivered
		• Review of Access policy (underway)	Access policy shared with other providers and CCGs – AH	Sept 18	Complete and shared with partners
		• Assurance that all capacity is being fully utilised	Forward look tool and weekly assurance meetings being developed - SW	Sept 18	Complete – regular meetings in place

Strategic Priority:

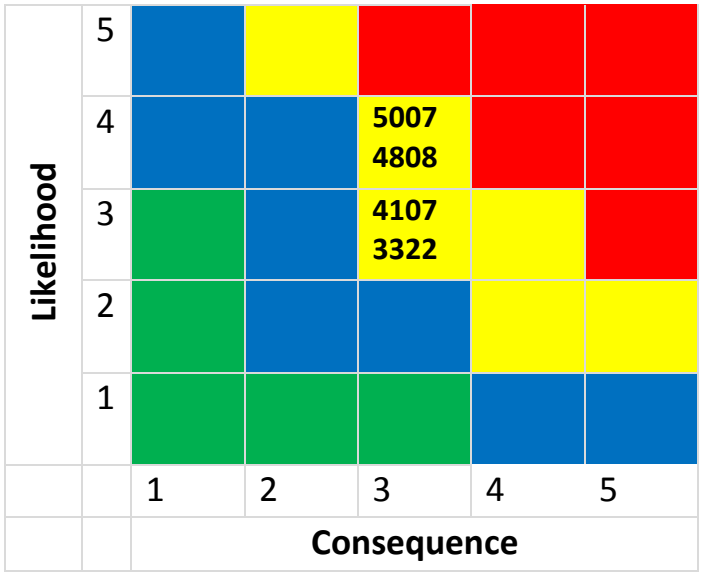
> **Specialist Services –** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance & Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Spinal Centre –** Service improvement initiatives within Spinal Cord Injury Centre	MD	April 2018 (Phase 1) Phase 2 tbc	
2. **Plastics** - Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO	Dec 2018	
3. **Partnership Working** - Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD	June 2018 (Phase 1)	

Corporate Risk Register Principal Linked Risks



3322 - Genetics National reconfiguration
4808 - Vascular surgery cover
5007 – Endoscopy unit JAG accreditation –

Linked risks:

4107 - Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients. (Care section)

Key Controls	Assurance on Controls
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group	• Integrated Performance Report • Specialist Services dashboards

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Service improvement initiatives within Spinal Cord Injury Centre	• Reducing the delay to admission and acceptance of admissions. • Reducing LoS by introducing intense rehab and standardisation of care, whilst also introducing a step down facility for rehab. • Ensuring a sustainable outpatient model, with every patient being recorded. • Improved therapy	• The historical and cultural national referral process restrictions. • Workforce gaps in staffing levels and conflicting priorities. • Levels of therapy engagement resulted in pilot work being stopped.	Delivery of the spinal action plan	TBC	Complete
		• Multi-disciplinary ward round, including support from urology not yet implemented and embedded	Recruitment of spinal urologist	Sept 18 Recruitment process commenced	Interview 07/01/19 – awaiting outcome

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
	collaborative working across patient pathway, including inpatient and outpatient services • Recruitment of a clinical lead to support change within the teams • Implemented and embedded multi-disciplinary ward round, including support from respiratory • Improvement plan in place and maintained via Directorate Performance Reviews	• Common MDT vision and strategy not yet developed	Delivery of the spinal action plan	TBC	Complete
2. Plastic Surgery: Deliver capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	• Theatre timetables have been redesigned to ensure that elective and emergency capacity is separated • Support to PHT to become sustainable out of hours • Network approach to Plastic surgery service provision • Recruited band 7 lead for Plastics and Burns	• Required changes to operational and clinical practice/behaviour associated with reconfiguration of Burns and Plastics Inpatient Ward is not yet embedded	COO monitoring numbers and location of outliers – AH	Ongoing	Implemented and on-going
		• SLAs for providing services to other Trusts are not in place across the network	Trust wide piece of work to establish SLAs with other Trusts - AH	~~Aug 18~~ Jan 19	Newly set up plastics network is identifying the need to reflect in the SLA
		• Changes in operational practice from relocation of weekend Plastics Trauma Clinics to Burns and Plastics Inpatient dept	Monitoring via Executive Performance Reviews with MSK - AH	Ongoing	Implemented and on-going
		• Workforce and skills gaps in Nursing Team	Trust wide recruitment programme for nursing – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
			Working with Deputy Director of nursing to mitigate training risk - AH	July 18	Complete
		• Gap between income and expenditure in plastics and burns	Implement action plan - AH	Mar 19	
		Effect of changes in capacity and pathways in other Trusts affecting flow of patients to SFT	Plastics network launched – AH	July 18	Complete
			Meeting with Southampton Trauma Director - AH	Sept 18	Complete
			Meeting with COO of Portsmouth - AH	~~Sept 18~~ Dec 18	Meetings cancelled by Portsmouth so action closed
3. Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genetics/genomics)	• Cleft appointed new consultant cleft surgeon, who is also rotated on the plastic surgery O/C rota. • Work continues with Oxford and Southampton in ensuring the appropriate site is available for cleft surgery • Genetics - good progress in forming an alliance partnership with BWCH, UHB, OUH and UHS	• As part of the national tender process for genetics/genomics the following gaps have emerged: - Clarity on what genetics services will continue to be offered at SFT - Clarity on genetics service implications for workforce, estates and infrastructure • Forum for discussing pathways with Southampton as the tertiary provider • NHSE Commissioning approach for genetics from 1 October 2018	Responding to NHSE requests for further information in advance of procurement decision - LA	Ongoing	Implemented and on-going
			Meeting with Southampton regarding laboratory services - LA	10 Aug & 5 Sept	Meetings held. Non agreement
			Quarterly meetings between MDs and COOs - AH	Dec 18	All actions now superseded with the creation of the consortium which is now in place and progressing the agenda
			Continue to engage with commissioners and consider implications of new commissioning arrangements - LA	Dec 18	

Strategic Priority:

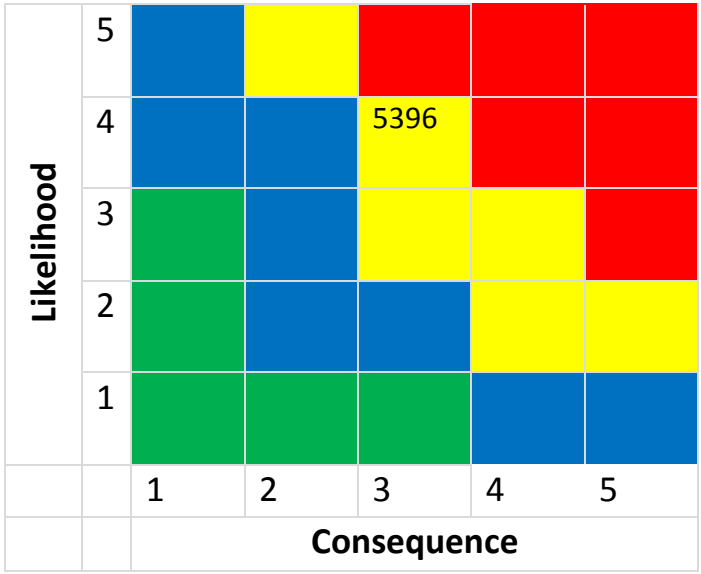
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: Medical Director **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Research -** Deliver an increased range of high quality research which directly benefits patient care and increases the Trust's reputation	MD	April 2019	
2. **Improvement -** Build a culture of innovation and continuous improvement	COO/MD	Oct 18	
3. **Innovation -** Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO	April 2019	

Corporate Risk Register Principal Risks



Linked risks:

5396 – Delivery of CQUIN (resources section)

Key Controls	Assurance on Controls
• Outstanding Every Time Board • QI training and coordination via PMO • Research Governance Framework	• Model Hospital benchmarking • NIHR Wessex

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	• Attaining recruitment target • Increased number of departments are research active • Good progress in recruiting to time and target • Team won national Research Excellence Award • Approval to recruit two research fellows from NIHR support • Reviewing NIHR bulletins monthly to identify suitable studies • Exceeding recruitment target for Q3	Nil at present		Monthly	Complete
2. Build a culture of innovation and continuous improvement adopting a consistent QI methodology	• Business case approved setting out future QI approach	Historically there has been no consistent approach to QI. Business case not funded; alternatives being explored Fragmented capture of QI work within the Trust and unclear accountability for delivery	Scope current QI activity, capacity and capability in the organisation – LW/LAr	End Oct 18	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
3. Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	• Trust weighted activity unit benchmark in top 10% of country as per the Model Hospital tool. • Consistently approving introduction of new procedures • New ambulatory gynaecology service • Introduction of virtual fracture clinic and patient initiated follow up • Roll out of email advice service	Surgical pathway requires improvement to reduce pre-surgery bed days	Length of Stay Project Board to identify pathways with excessive length of stay	Q2 18/19	Complete In upper quartile on model hospital
		Failure to embed standard operating procedure for Fractured neck of femur pathway	Review pathway for fractured neck of femur with a view to making improvements	Q2	Complete Pathway reviewed and controls in place
		Gaps in communications with GPs due to Consultant Connect not being commissioned for SFT	Joint GP and consultant session to review	July 18	Complete

Strategic Priority:

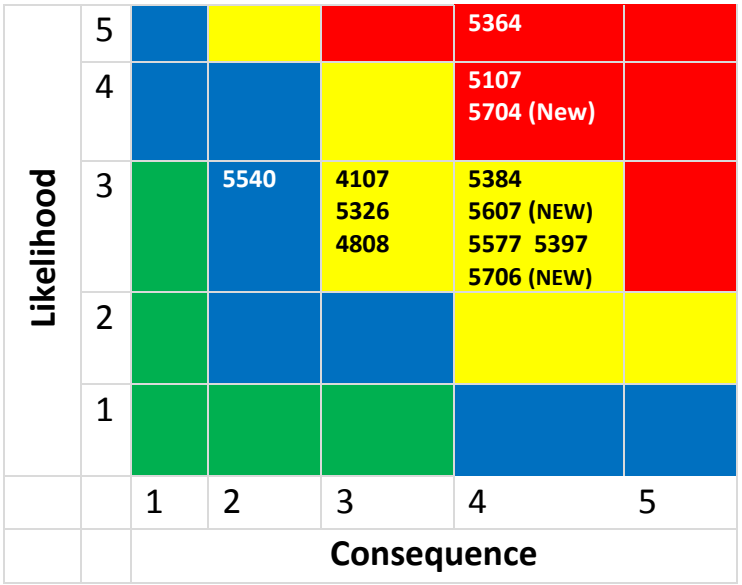
Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

Executive Lead: Medical Director and Director of Nursing **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **CQC** - Achieve a CQC rating of Good	DoN	March 19	
2. **Safety -** Deliver on the local and national safety priorities	DoN	March 19	
3. **Infection -** Maintain our focus on reducing rates of infection	DoN	March 19	
4. **Learning from Deaths -** Review process to establish learning and improvement	MD	March 19	
5. **Patient Experience -** Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN	March 19	

Corporate Risk Register Principal Risks



5384 – inpatient fall resulting in harm; increasing frail population
4107 – Risk of delay to patient follow-ups in Plastics
5577 – Risk to patient safety from overcrowded ED
5540 - Potential impact of HSIB investigation processes on Trust's own governance processes
5607 - Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing (Care): **NEW**
5704 - Inability to provide a full gastroenterology service due to a lack of medical staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed (Care): **NEW**
5706 - Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment (Care): **NEW**
Linked risks:
4808 - Vascular surgery cover (specialist services section)
5107 - Failure to recruit to vacant posts will result in an inability to provide outstanding patient care (people section)
5364 - Failure to achieve required ward nursing establishment (people)
5326 – Access to electronically held patient records (resources)
5397 - inability to recruit enough nurses a decision has been taken not to open the additional medical beds (local services)

Key Controls	Assurance on Controls
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Policies and procedures • Patient and user feedback mechanisms / patient stories at Board • Contract Quality Review Meeting / contractual monitoring • Annual audit programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review-completed March 18 • Internal Audit report on morbidity and mortality meetings

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Achieve a CQC rating of Good	• Positive CQC Insights report on key benchmarks • Improvement delivery on Must do/ Should do's	• CQC will not normally grade a Trust Good if it is subject to NHS I enforcement action • Findings of Well Led review have identified areas for improvement	Continue to deliver the Enforcement Action Plan to close enforcement action and obtain NHS I certificate of compliance	September 2018	DoF having discussion with NHSI re: future actions. Update on enforcement action plan taken to Nov F&P Committee
			Complete CQC inspection preparation - LW	Nov 18	Complete
			Implement Well Led action plan – CCB/FMc	Dec 18	Action plan progressing and additional actions included. Monthly monitoring through Execs
2. Deliver on the local and national safety priorities	• Quarterly reports show most workstreams on track	• Never events continue to be reported	Intensive support commissioned for theatres – led by DMT with Executive oversight	Sept 18	Complete
		• Falls continues to be biggest risk within the work streams • Poor compliance with falls risk assessments	Implementation of Falls Reduction Strategy	March 19	

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
		• Cluster of incidents relating to cancer pathway	Task and finish group set up and chaired by deputy COO to review patient pathways and processes – AH	April 18	Complete
			Draw together learning from all incidents for review by Clinical Risk Group, Cancer Board and CCG – LW/CB/AH	Sept 18	Complete
			Cancer Board review of patient pathways and MDT efficiencies – CB	~~Sept 18~~ March 19	Significant piece of work. Deadline revised
3. Maintain our focus on reducing rates of infection	• Trust in best performing quartile for reportable infection rates in the South West in 2017/18 • Positive feedback received from NHS England re reduction of E. coli bacteraemia	• Did not achieve the required reduction in defined daily doses across all anti-microbials for CQUIN 17/18 • Currently do not have resource required to have adequate oversight of anti-microbial stewardship in practice	CSFS business case addressing gaps and potential resource requirements	~~Sept 18~~ 31/03/19	Deadline revised as not progressed
4. Review process to establish learning and improvement on learning from deaths	• Mortality review reports show low levels of avoidability • HSMR is in normal range • Internal audit report on morbidity and mortality meetings • Learning from Deaths Policy published on Trust website • Mortality dashboard was published in February	• Improvement needed in some local Mortality and Morbidity meetings	Ongoing work with relevant directorates – CB	Ongoing	
		Improvement needed in mortality review tool	Improvement work prioritised by IT – CB	Sept 18	The mortality tool has been redesigned but it has not been released into the live environment

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
					yet. The reason is that a Medical Examiner section needs to be included which must be live by March and the IT developer is away until 17 December. In the meantime, we are continuing with the existing system which is adequate for our needs at present.
5. Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	• Positive survey results o ED o Cancer o Maternity o Paeds • High satisfaction shown in Friends and Family Test and Real Time Feedback	Not yet achieving improvement on NHS Inpatient Survey results (all areas average)	Action plan in development, with key focus for corporate support being established - LW	Sept 18	Complete

Strategic Priority:

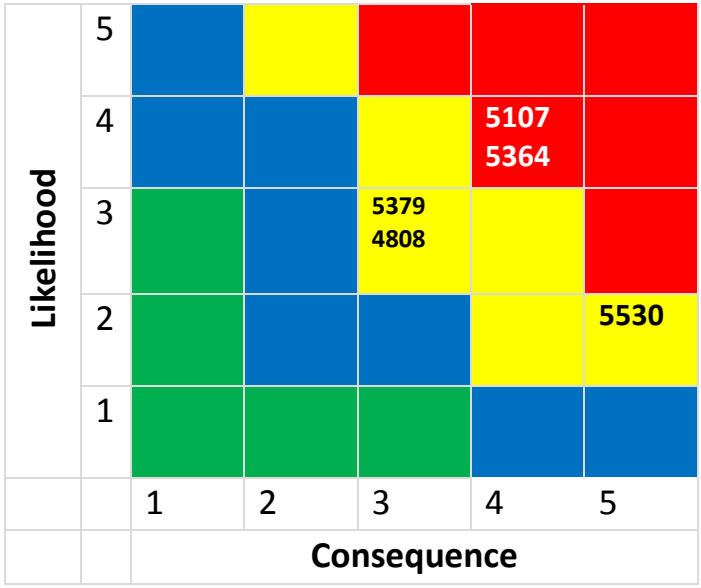
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: Director of Organisational Development and People **Reporting Committee:** Workforce Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Resourcing and Talent Management -** Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP	March 2019 (phase 1)	
2. **Business Partnering** - Establish effective partnerships to align business and HR strategies	DoODP	March 2019 (phase 1)	
3. **Health and Wellbeing** - Improve the health and wellbeing of staff	DoODP	March 2019 (phase 1)	
4. **OD and Engagement** - Develop a diverse and inclusive culture where staff feel engaged	DoODP	March 2019 (phase 1)	
5. **Leadership -** Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP	March 2019 (phase 1)	

Corporate Risk Register Principal Risks



5107 – High level of vacant clinical posts incurs costs due to increasing use of agency staff

5364 - Failure to achieve ward nursing establishment

5530 – Consultation on wholly owned subsidiary proposal

Linked risks:
5379 – Theatres patient safety (care section)
4808 – Vascular surgery cover (specialist services section)

Key Controls	Assurance on Controls
• Workforce Committee (EWC) • Health and Wellbeing Board • HR Policies • Directorate Performance meetings • Trust values and behaviours • Workforce Programme Management Board • Safer Staffing Group • Equality, Diversity and Inclusion Steering Group (under review) • Health and Safety Committee • Integrated Performance Report at Board • Monthly Workforce Dashboard • Executive Safety Walks • Freedom to Speak Up Guardians • JCC Staff Side Meeting	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	• Staff turnover remains steady (reported through EWC) • Growing medical locum bank (Locums Nest engaged) • Engaged with regional streamlining work stream • Engaged with STP Agency cap and control work stream • Chair of the STP Social Partnership Forum • Proactive engagement with the Local Workforce Action Board	• Impact of Brexit not yet clear	Continue to review as new information becomes available	Ongoing	Staff led Brexit group established Nov 18
		• Impact and delay of IELTS / OSCE for international recruits	Explore alternative IETLTs rules with NMC	July 2018	Complete
		• Recruitment data not easily reportable	TRAC system due to go live July 18 - PH	July 18	Complete
		• No retention strategy and associated resource	Implement Engagement Plan	~~July 18~~ Jan 19	Action aligned to operating plan deadline
		• Potential for shortage areas to be removed from Shortage Occupation list (e.g. Nursing)	Continue external conversations and ensure awareness of proposed	Ongoing	Complete Change in Government

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
	• Staff side balloting on government proposals on Agenda for Change		changes		process has enabled the Trust to obtain Tier 2 visas. No longer a gap in control
		Process not in place to gather recruitment experience	• Implement recruitment strategy – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan
			• Procurement of TRAC recruitment system — PH	Q3 18/19	Complete
		Implementation of new approaches to retention	Pilot innovative approaches to retention e.g. transfer windows	July 18 – Jan 19	'Stay' conversation commenced November 18
		Feedback gaps (candidate/ starter/ leaver)	Exit interviews –- PH 100 day new starter survey - PH	March 18 June 18	Commenced Commenced
		Inability to triangulate hard and soft metrics on wellbeing of staff /depts	Triangulating hard and soft workforce metrics - PH	Q2 18/19	Action closed as duplicated below
		E-Roster not rolled out to wider workforce	Integration and roll out of eRoster –PH	Q4 18/19	
		Resourcing strategy does not align temporary and substantive staffing needs	Transfer of Bank function into OD & People Directorate – PH	~~Q3 18/19~~ Date TBC	Work commenced. Alignment period with HR and nursing

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
					working together for transition. Implementation date TBA
		Programme of staff benefits not fully developed	Programme of staff benefits –PH	~~Q2 18/19~~ March 19	Options appraisal underway. Action aligned to operating plan deadline
2. Establish effective partnerships to align business and HR strategies	• New Workforce KPI Dashboard • New structure for HR implemented 3 April with vacancies going out and some interim cover	• Lack of management training and toolkits on key people management topics	Rolling programme commencing Q1 – PH - First tool kit – sickness absence	Q1 18/19	Commenced
		• Maximising ESR system capabilities – inaccurate establishment hierarchy in ESR	Optimise use of ESR to enable accurate reporting and feeder systems to function - PH	March 19	ESR group established. Business case for December
		• Current inability to triangulate hard and soft data across the organisation	Triangulating hard and soft workforce metrics - PH	~~Q2 18/19~~ ~~Dec 18~~ 30/06/2019	Paper being presented at Workforce Committee January 19. Investment required. Deadline revised
		• Immature Business partner model for service delivery	• Appoint to vacant senior posts –- PH	~~Q3 18/19~~ ~~In progress~~ 31/03/2019	Failed to appoint following Nov 18. Re-advertising Jan

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
					19interviews. Deadline revised
3. Improve the health and wellbeing of staff	• Staff sickness benchmarks well against local Trusts at approx 3.6% as an average. • Shape up at Salisbury offering for staff well supported. • Onsite Occupational Health and staff counselling services • Over 70% of front line staff vaccinated against influenza	• Staff sickness remains above 3% target • Sickness absence management inconsistent • Sickness absence reporting processes and data not robust • Current inability to triangulate hard and soft data across depts.	• Redesign electronic sickness reporting process – PH	Q4 18/19	
			• New sickness absence policy –- PH	Q1 18/19	Completed
			• Managers' tool kit – PH	Q3 18/19	In place for sickness. Further development planned
			• Health & Well Being Strategy –- PH	~~Q2 18/19~~ ~~Dec 18~~ 31/03/2019	New lead commenced Jan 19. Strategy aligned to operating plan. Deadline revised
			• Trust wide E-Roster roll out to provide real time sickness data - PH	Q4 18/19	
4. Develop a diverse and inclusive culture where staff feel	• Staff survey results in upper quartile nationally • Staff Friends and Family Test	• Mandatory Training compliance above target of 85% • Appraisal rates for non-medical	L&D full service review –PH	Q2 18/19	Complete Department re-structured

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
engaged	results are positive • WRES Trust action plan in place • Publication of Trust's Gender Pay Report	staff remain below target of 85% • Funding gap for education and training	Delivery of the operating plan	March 19	
5. Develop strong leadership capability across all levels of the organisation to support an innovation culture	• Leadership programmes in place • Strong relationships with local providers • Values embedded • Equality and Diversity System 2 (EDS2) in place	• Lack of robust talent management and leadership development programme across the Trust. • Leadership programme not aligned to culture (in development	OD and engagement plan implementation - PH	~~Q3 18/19~~ 31/03/2019	Paper to Workforce Committee January 19. Alignment to operating plan. Deadline revised
		• Lack of comprehensive engagement and communication strategy in place.	Service redesign and delivery following L&D full service review — PH	~~Q3 18/19~~ 31/03/2019	To be completed by J Scrase on return end January 19.

Strategic Priority:

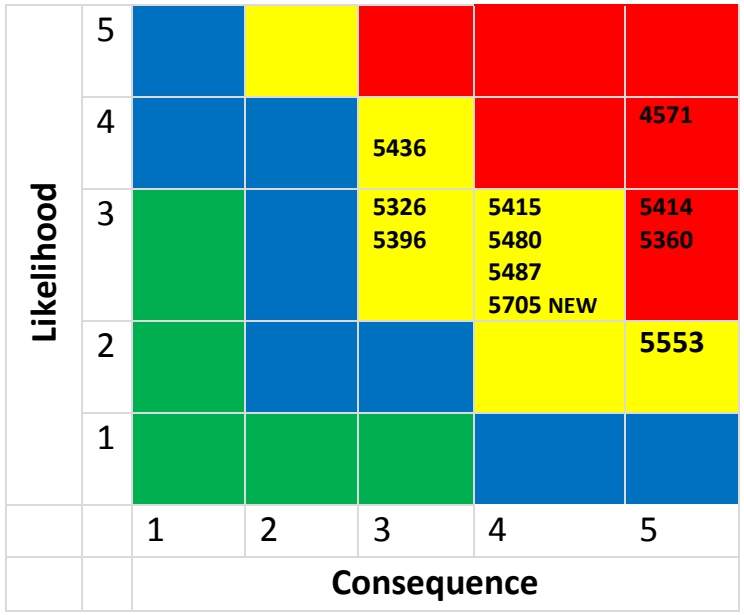
> **Resources –** We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Executive Lead: Director of Finance **Reporting Committee:** Finance & Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Financial Recovery Plan -** Deliver on financial recovery plan to secure financial sustainability	DoF	March 2019	
2. **Campus Scheme** - Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD	April 2021	
3. **Digital Strategy -** Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD	April 2021	
4. **Service Reviews -** Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD	March 2018	

Corporate Risk Register Principal Risks



5326 - Review, PACS, POET, Lorenzo, WinDip & Paper Records
5396 – Delivery of CQUIN
5415 – Funding of all capital expenditure
5414 – Achievement for 2018/19 financial plan
5480 – Control of quality of information submitted externally
4571 - Potentail failure of sterilisers, washers and associated plant
5553 – SUS/SLAM reconciliation
5487 - Subsidiary impact on financial position
5360 - Risk of cyber attack
5705 - Impact on the daily running of the hospital as a result of Great Britain's exit from the European Union **(NEW)**

Linked risks:
5436 – Funding for quality improvement (QI) methodology (Innovation section)

Key Controls	Assurance on Controls
• Finance and Performance Committee • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • Strategy Committee	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver on financial recovery plan to secure financial sustainability	• Outstanding Every time Board established with CEO chairing monthly • Plan developed with savings opportunities identified as part of the financial plan 2018/19 • Transformation Director appointed (commenced April 18)	• Engagement with STP and Commissioners on SFT recovery plan	Continue to actively participate in STP recovery plan actions – LT/CB/LA/CCB	Ongoing	Implemented and on-going
		• Capability and capacity across the organisation to deliver change at pace	Transformation Director to identify gaps - SW	Ongoing	Completed
		• Recruitment challenges across the organisation limit delivery of the plan	Implement recruitment strategy – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan
		• Two-year financial recovery and sustainability plan yet to be finalised	Submit 2 year financial recovery and sustainability plan – LT	9 July 18	Complete

			Further work on 2 year financial recovery and sustainability plan following NHSI feedback - LT	~~Oct 18~~ 31/01/19	Re-submission due Jan 19
		• Action plan to be completed in response to NHSI Enforcement Letter	Delivery against action plan - LT	Ongoing	Nov 18 update to F&P Committee
2. Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	• Additional management capacity with experience in delivering similar projects secured • National schemes are coming on line which offer potential frameworks for development • Support from Wiltshire Council and commissioners for proposed scheme • Advanced discussions with potential private sector partner for Joint Venture agreement • Positive early clinical engagement • Communication/PR expertise appointed • Strategy Committee commenced in March 2018 • Signed agreement for private sector partner • Master planning commenced and working effectively • Submitted capital bid for low risk maternity unit	• Link into wider Trust strategic estate plans needs strengthening	Produce strategic estates plan – LA	~~Sept 18~~ ~~28/02/2019~~ 31/03/2019	Estates Strategy on March Board agenda. Deadline revised
		• Absence of detail to progress financial modelling	Development of overarching business case - LA	~~Dec 18~~ 30/06/19	Extensive piece of work. Deadline revised to 30/06/19
3. Develop and implement a digital strategy	• Early draft of document developed to begin consultation • Foundation of an integrated	• Delay in subsequent phases of EPR, delivery against business case • System supplier engagement	Escalation of issues at director level with supplier – LA	Dec18	Complete

which will enable the delivery of more effective care through the use of technology	patient record system exists which can be linked to other systems • Strong engagement from some clinical quarters, eg nursing • External support commissioned to support development of digital strategy	• Because of usability issues, risk around engagement • Lack of capital funds to invest (potential national funds will be allocated by the STP) • Gap in control due to pharmacy resources to progress the business case	Develop business case for Electronic Prescribing – CB/LA	Oct 18	Business case developed
		• Need to redefine the role of ISSG in taking forward the digital strategy	Redefine role following agreement of digital strategy– LA	Oct 18	Complete
		• Difficulties from information held in both paper and digital form	Develop Digital Strategy – LA	~~Sept 18~~ March 19	Going to Nov Strategy Committee with plan for Board in Dec 18. Now to Board in March 19
			Further development of EPR in line with digital strategy, on a module-by-module basis commencing with electronic prescribing – LA	~~Q3, 2018~~ Jan 19	
4. Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	• Outstanding Every time Board established with CEO chairing monthly to oversee programme. • Additional capacity procured to support the development and delivery of the recovery programme (core services one element)	• Timeliness of publication of relevant benchmarking information to support decision making. • Capacity to undertake reviews then implement change at pace. • Structured framework to evaluate core clinical services for	Improvement plan process to be agreed	Nov 18	Complete
			Project plan and governance in place for GIRFT review	Nov 18	Complete

	• Use of Model hospital and GIRFT to support pathway change in place.	sustainability	Review of the Model Hospital to support improvement programme2019/20	Jan 19	

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5540	Clinical Support and Family Services	Maternity Administration	17/09/2018	Clinical Governance	6	In November 2017, the Secretary of State for Health published a refreshed National Maternity Safety Strategy Safer Maternity Care announcing plans for HSIB to undertake around 1000 independent safety investigations. HSIB are now investigating cases of intrapartum stillbirth, early neonatal deaths and severe brain injuries from 37 weeks gestation that occur at SDH as part of a national programme of work. There is a risk that as these investigations are being undertaken externally and independently to the Trust there would be a failure to meet our internal governance standards. There will be a lack of early knowledge and full understanding of incident thus preventing support to staff, openness and honesty with families and potential implications for patient safety if learning at the earliest opportunity is not undertaken. The trust will hold no information in house that would advise and support cases should they be pursued at a later date through the litigation pathway or through a HR process. It may also create a barrier between the hospital and families involved which will be counter productive to the embedded open and honest approach that the department has established.	May recur occasionally	Minor	6	To await first HSIB investigation report to gain a full understanding of the scope and quality of the review in order to understand how and what has been addressed.	28/02/2019		Melbourne, Kim	Clinical Risk Group	28/02/2019	2	Care	Trust Board (Corporate Risk Register)	Director of Nursing
										The Director of Nursing and the Head of Gynaecology are to work with HSIB to fully explore these concerns.	28/02/2019		Wilkinson, Lorna						

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
3322	Clinical Support and Family Services	Genetics	29/08/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury. 05/07/2018 CAW: Funding flows for Genetic testing will change following re-procurement. NHSE planned start date is 1st Oct 2018. SNHSFT will no longer be commissioned for Genetic tests via the SW specialist services commissioning group so the Block contract will end. Instead funding for rare and inherited genetic tests will be received via the Genomics Hub (Birmingham). All acquired cancer genetic tests will be moved to provider to provider funding. This includes many haemato-oncology tests currently funded by the Block contract (estimated £900k p.a.)Referring departments will be expected to fund genetic tests from within tariff. There is therefore a risk that income will be reduced if Clinicians/Trusts have to mitigate against the increased costs by applying greater clinical thresholds to testing. 20-12-18: Funding arrangement for 2019/20 likely to be rolled over by NHSE.	May recur occasionally	Moderate	9	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named "re-procurement" Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid. Update Oct 18: Wessex Oxford and West Midland Genomics Consortium (WOWMC)has been established and chosen as the preferred provider of genetic/genomic diagnostic testing for Wessex, The West Midlands, Oxfordshire and Thames Valley. The Central Laboratory Hub will be in Birmingham.	01/04/2018	25/01/2018	Blanshard, Dr Christine	Trust Board	31/01/2019	6	Specialist Services	Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	Medical Director
										Tender document issued. Alliance formed with UHB, BWCH, OUH and UHS to respond to the tender. BWCH proposed to become the central laboratory hub and WRGL will become a local genomics laboratory.	31/10/2018	30/11/2018	Blanshard, Dr Christine						
										Need to consolidate DNA extraction into a single lab in Wessex. Will require negotiations with UHS.	31/01/2019		Burwell, Jonathan						
										Communication plan with referring hospitals to inform they will be required to fund cancer testing from tariff.	31/01/2019		Blanshard, Dr Christine						

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4107	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	17/09/2015	Service Delivery Plan, Specialty Risk assessment	12	Failure to adhere to clinician requested timeframes for follow-up appointments for cancer patients . Risk of clinical deterioration in between follow-ups which could lead to untreatable disease progression. This risk relates to outpatients and to patients needing local anaesthetics (the risk to patients needing local anaesthetics was previously on risk 5421 which was merged with this risk on 07/01/19). Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour. SEE ALSO CLOSED RISK ID 5421	May recur occasionally	Moderate	9	Further recruitment of 2 plastics consultants	18/12/2015	11/10/2016	Wright, Jonathan	Directorate Management Team Meeting	31/01/2019	6	Care	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Chief Operating Officer
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	17/01/2017	25/01/2018	Insull, Victoria						
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	17/01/2018	17/01/2018	Insull, Victoria						
										monitor and review capacity and time to follow up	31/12/2018	21/12/2018	Vandyken, Ali						
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	30/04/2018	08/05/2018	Hyett, Andy						
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	31/08/2018	16/08/2018	Hyett, Andy						
										Full follow up PTL being validated at patient level for 2017 and 2018.	29/03/2019		Hyett, Andy						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5326	Corporate Development	Electronic Patient Record Team	20/12/2017	Electronic Patient Record	6	Review, PACS, POET, Lorenzo, WinDip & Paper Records - information in these systems are required to fully assess patients - access is required to all the above systems and there is a risk that information may be missed due to overhead of access and or clarity on what information is where - leading to inefficiency delays and potential patient harm	May recur occasionally	Moderate	9	Training review being commissioned to provide holistic training for clinical staff	31/01/2019		Lees, Susan	Electronic Patient Record	19/02/2019	4	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Describe within digital strategy how information from a range of sources will be used	07/03/2019		Burwell, Jonathan						
										Set up governance structure for development of digital strategy	28/09/2018	24/10/2018	Arnold, Laurence						
										Secure support from clinicians to be CCIO and Clinical safety officer	30/10/2018	24/10/2018	Blanshard, Dr Christine						
										Upgrade to WinDip	31/01/2019		Ford, Nicola						

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5396	Quality Directorate	Trustwide	04/04/2018	Commissioning for Quality & Innovation (CQUIN)	16	Potential non delivery of CQUIN schemes that are high risk: 1a - improvement of health and wellbeing of NHS staff - 5% improvement in 2 out of 3 questions in the staff survey required. Responses to all 3 questions decreased between 2016 & 2017 survey. £138K at risk. 1C - Improving uptake of flu vaccine for front line staff - no opt out for West Hampshire. Target increased from 70% - 75% and includes all temporary staff. £34k at risk. 2A & 2B - Sepsis - achievement of 90% of inpatients with severe sepsis screened and given IV antibiotics within 1 hour of diagnosis may not only achieve a partial payment due to small numbers. £62K at risk 2D - Antibiotic consumption reduction - 2% reduction on 17/18 baseline in total antibiotic consumption and an increase to > 55% in the proportion of antibiotics usage within the Access group of the AWaRe category. £69K at risk. 9A - Reducing risky behaviours - achieving 90% screening of all inpatients for smoking due to sheer volume of patients. £2.5K at risk. 19/7/18 Monies at risk £305.5K at year end. 31/12/18 Wiltshire CCG and associates have agreed the payment of CQUIN in full as we have achieved over 50% compliance in Q1 and Q2 18/19.	May recur occasionally	Moderate	9	Reduce the level of work related stress and MSK work related problems in groups of staff who have the highest rates. Target high risk groups for action through work led by DD of HR and staff & health wellbeing group. Actively promote the staff health and wellbeing programme.	30/01/2019		Hargreaves, Paul	Finance and Performance Committee	30/04/2019	6	Innovation, Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Increase the uptake of the flu vaccine of front line staff by running a comprehensive flu campaign based on learning in 17/18.	31/01/2019	30/01/2019	Major, Denise						
										Improve the screening and treatment of inpatients for severe sepsis by continuation of the current ward based CCOT education programme, regular feedback on timeliness of screening and IV antibiotics audit. Monitor progress through the Sepsis working group.	31/07/2018	31/07/2018	Finneran, Dr Nicola						
										Reduce the consumption of carbapenem by 2% on the 17/18 baseline.	31/10/2018	02/11/2018	Williams, Lou						
										This action is no longer relevant as NHSE withdrew the requirement of a 10% reduction in all people who attend ED with mental health needs who had a personalised care plan. Instead a 2nd cohort was identified with specific work tailored to their needs to help them reduce ED attendances.	19/07/2018	19/07/2018	Davies, Dr Stephen						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
						achieved over 90% compliance in Q1 and Q2 18/19. 30/1/2019 Monies at risk increased to £363K at year end as in Q3 failed to meet 90% target of NHSE CA2 SACT scheme - mitigated by working with UHS on priority drugs to be dose banded. Year end deal in place of £65K loss on CQUINs compared to an actual loss of £237K)				Screen 90% of inpatients for alcohol and smoking by the ward pharmacy teams. Review screening data weekly until 90% is sustained.	31/07/2018	31/07/2018	Smale, Maria					
										Reduce the consumption of all antibiotics by 2% on the 17/18 baseline.	31/01/2019		Williams, Lou						
										Increase to >55% in the proportion of antibiotic usage within the Access group of the AWaRe category.	31/01/2019		Williams, Lou						
										Consider the introduction of antibiotic stewardship rounds, education and feedback to individual clinicians and teams on practice.	31/01/2019		Williams, Lou						
										Take part in antibiotic awareness week. Agree protocol changes at the Infection Prevention and Control Group.	31/01/2019		Williams, Lou						

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5553	Corporate Development	Trustwide	21/08/2018	Data quality	15	SFT send a regular data feed to the secondary usage service (SUS) which should be broadly consistent with the contractual data provided - the contract requires within 2%. An incident occurred whereby the year end SUS refresh greatly exceeded that level putting into question the lack of a robust reconciliation process.	Do not expect it to happen again but it is possible	Catastrophic	10	Documented process for Monthly SUS Slam Reconciliation.	31/01/2019		Mortimore, Martin	Audit Committee	19/02/2019	5	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Reconciliation Dashboard for PbR to be finalised and published for key internal stakeholders access.	12/12/2018	19/12/2018	Mortimore, Martin						
										Trust to support CSU to update commissioner reporting with accurate 2017/18 dataset for outpatients.	02/11/2018	08/11/2018	Anscombe, Felicity						
5530	Trustwide	Trustwide	11/09/2018	Trustwide risk assessment	15	Formal consultation with Estates, Facilities and Procurement staff commenced on 3rd September, the proposal being to move services into a 'wholly owned subsidiary'. UNISON have indicated that they plan to ballot members (after Christmas) for industrial action. A range of action up to and including strike action may result, additionally, the risk that other staff groups support this action should not be underestimated. The removal of labour would have a significant effect on the delivery of services including (but not limited too), switchboard services, patient movement, provision of food for patients, cleaning services the maintenance of utilities and the processing of orders (Trust wide).	Do not expect it to happen again but it is possible	Catastrophic	10	To identify the scope and scale of any industrial action and plan to mitigate (where possible) the actions to limit the effect of this upon the delivery of patient care.	31/03/2019		Robinson, Ian	Trust Board	31/03/2019	4		Trust Board (Corporate Risk Register)	Director of Finance
										New guidance published by NHSI. Board will consider in February 2019.	28/02/2019		Thomas, Lisa						

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5384	Quality Directorate	Trustwide	29/03/2018	Incident reports	12	Risk of patients within hospital experiencing a fall resulting in injury. This is an issue recognised nationally due to the increasing frail population.	May recur occasionally	Major	12	Create version 2 of nursing post falls assessment sticker for cascade out across the Trust.	28/02/2019		Brewin, Georgette	Falls Group	31/01/2019	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Implementation of nursing assessment documentation which incorporates a multifunctional assessment and intervention form.	30/04/2018	02/05/2018	COLLK						
										Compliance audits of falls care plans and interventions.	28/09/2018	16/10/2018	COLLK						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018	15/08/2018	Benson, Rebekah						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018	29/03/2018	Wilding, Henry						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018	15/08/2018	Dunn, Bernie						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018	15/08/2018	Montgomery, Alison						
										Refreshed Share and Learn sessions	30/04/2018	02/05/2018	Major, Denise						
										Participate in NHSI Falls Collaborative.	03/12/2018	20/12/2018	Major, Denise						

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5415	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	12	There is a risk that the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability. This could lead to a negative impact on the delivery/quality of care, the ability to achieve performance and access targets and the ability to transform and innovate to become more efficient.	May recur occasionally	Major	12	Trust identifying opportunities for additional capital funding as per STP (8th June). 22/6/18 - Trust submitted bids for Cath Lab and Maternity to STP, awaiting outcome.	29/06/2018	22/06/2018	Thomas, Lisa	Finance and Performance Committee	28/02/2019	12	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Business being developed for Cath lab funding as a material risk in year- end of June	28/02/2019		Thomas, Lisa						
										Trust currently has slippage against capital programme, evaluation of capital forecast and potential spend for Q4 presented to F&P in January	22/01/2019		Thomas, Lisa						
5480	Corporate Development	Trustwide	23/07/2018	Incident reports	16	Risk is that information leaves the organisation from a number of sources and there is not adequate control over the quality of the information submitted and ensuring that the information meets the need for which it is being produced and does not cause reputational harm or misinform.	May recur occasionally	Major	12	Agree content and approach to undertaking analysis work and reporting approach to IGSG	31/08/2018	01/11/2018	Doubtfire-Lynn, Heidi	Audit Committee	19/02/2019	6	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Corporate Development
										Complete Serious Incident Inquiry in order to review what additional controls require adding.	30/11/2018	02/11/2018	Arnold, Laurence						
										Creation of Information Standards Committee to oversee external information accuracy and timeliness	31/01/2019		Burwell, Jonathan						

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5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation.	May recur occasionally	Major	12	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	29/03/2019	9		Trust Board (Corporate Risk Register)	Director of Finance
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	29/03/2019		Thomas, Lisa						
										Discussions with SWAST and other Paramedic providers re provision of Navigator role	31/01/2019		East, Rachael						
										Nurse recruitment at Band 5 and Band 6 level. Recruitment initiatives with HR - exploring social media, updating of adverts, updating of JDs, develop a B5 role solely for SSEU	31/01/2019		Heydon, Nicola						
										Skill mix review. Need for dedicated education lead/practise educator role (Band 7). 8pm - 2am shift to be piloted.	02/11/2018	09/11/2018	Heydon, Nicola						

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5577	Medicine	Emergency Department	02/10/2018	Departmental risk assessment	15	There is a risk to patient safety due to overcrowding in the ED and increasing time to first assessment and time to treatment. This is influenced by key staff shortages and increasing demand. Nursing vacancies have reached a level whereby a 24/7 rota with experienced and substantive staff is not possible and agency staffing is being used. There is a risk of failing the ED 4 hour constitutional standard due to increased demand, increased acuity and inability to transfer patients into wards. At peak times in ED there is a risk of ambulances waiting to handover for prolonged periods of time. The ambulance service implement a SOP to prevent ambulances being delayed. Ambulances queuing or SOP being implemented has implications for patient safety as staff work under increased pressure to move patients out of ED to create space. When the SOP is implemented, patients are managed by and ED member of staff in a trolley queue which is unsafe for patients.	May recur occasionally	Major	12	Promote early escalation to DM and/or site team to support patient flow and pulling of patients from ED to ease congestion.	30/11/2018	24/12/2018	Clarke, Lisa	Directorate Management Team Meeting	31/01/2019	10	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										To work towards an ED model for rapid assessment ands treatment across Majors and Minors in conjunction with senior decision makers in the Department	31/01/2019		Oaten, Rachel						
										Intensive support meetings implemented following submission of ED Improvement/Recovery Plan	16/11/2018	13/12/2018	Clarke, Lisa						
										Triage escalation plan to be developed to support early escalation at times of surge / inability to meet 15 min time to treatment.	19/10/2018	17/10/2018	Heydon, Nicola						
										Capacity issues are discussed twice daily at bed meetings. Clear agreed escalation plan only to be used with prior agreement from Exec on call. Medicine do have an additional ward (Laverstock) currently agreed not to open for 18/19 *Action transferred from risk 5516*	16/11/2018	24/12/2018	Clarke, Lisa						
										Ongoing monitoring of current controls as listed below. 1. Patient flow action plan 2. Emergency Department action plan 3. System action plan *Action transferred from risk 5516*	01/04/2019		Hyett, Andy						
5607	Surgery	All clinical areas	19/10/2018	Data quality, Incident reports	12	Hospital at night (H@N) data has shown a year on year increase in workload, but no increase in night team staffing. The workforce (originally set up in 2010) is regularly under pressure to manage the volume of new admissions and respond to unwell inpatients. The H@N management board feel there is a high risk of minor errors regularly occurring (i.e. delayed patient review & medicine prescriptions) and a risk of an occasional serious event, as a result of delayed review and intervention, particularly during busy periods, when the Trust is in escalation.	May recur occasionally	Major	12	Throughout the month of December the H@N board will monitor workload to examine the impact of extra workload due to winter pressures. The Clinical Lead for H@N will then escalate to DMT if appropriate.	31/01/2019		Payne, Gill	H@NT Management Board	31/01/2019	6	Care	Trust Board (Corporate Risk Register)	Director of Nursing

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5397	Operations Directorate	Trustwide	05/04/2018	Other assurance not listed	20	Due to an inability to recruit enough nurse a decision has been taken not to open the additional medical beds in line with bed modelling signed off by board. This presents a risk to performance, quality and finances. **Mitigation on this risk is linked to 5305**	May recur occasionally	Major	12	Daily KPI metrics being developed.	08/04/2018	10/05/2018	Hyett, Andy	Trust Board	31/01/2019	9	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Patient flow and medicine length of stay actions being brought together into one action plan	15/04/2018	10/05/2018	Hyett, Andy						
										Board to be briefed next week on possible mitigations and impact on income and contract delivery being built into financial modelling.	30/04/2018	01/05/2018	Thomas, Lisa						
										Ward level dashboards being developed	31/08/2018	31/08/2018	Arnold, Laurence						
										Consider opening additional medical ward in Q4.	31/01/2019		Hyett, Andy						
4808	Surgery	Vascular Assessment Unit and Diabetes Unit	26/09/2016	Departmental risk assessment	16	Vascular surgeon cover is provided from RBH at SDH onsite 3 days per week. Currently due to staffing issues RBH are unable to provide 3 days cover and clinics are being cancelled. Cover has been reduced to 1 day on most weeks, with some weeks there being none. As a result patients are being delayed in attending outpatients. Urgent patients may need to travel to RBH for treatment rather than SDH. Angio procedures are unable to be undertaken at SDH without onsite vascular cover which has resulted in cancellations. There is a lack of MDT meetings which has slowed progressing patients on their pathways and delays results and treatments to patients. The vascular department do not have access to advice and support when managing nurse led clinics or patient queries. Update 16/08/18: Service reinstated from RCBH into SFT. External review ongoing which we are participating in.	Will probably recur, but is not a persistent issue	Moderate	12	Meeting with RBH and SDH representatives to resolve issues regarding cross site IT access and on site IR provision	18/02/2018	11/06/2018	Drayton, Louise	Directorate Management Team Meeting	31/03/2019	3	Care, People, Specialist Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Escalate IR provision issues through Exec performance review process.	31/01/2018	30/04/2018	Drayton, Louise						
										Escalated to the Chief Exec, Medical Director & Chief operating officer equivalents at RBH	31/08/2018	16/08/2018	Hyett, Andy						
										Meeting scheduled for 12/09/18 between SFT and RBH on 12/09/18. Risk, actions, and target to be updated following meeting.	12/09/2018	02/11/2018	Hyett, Andy						
										Meet Bournemouth in Q4 to ensure service has been sustained and quality issues have not returned (with a view to closing this risk if there is a positive outcome from this meeting).	31/03/2019		Blanshard, Dr Christine						

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5007	Clinical Support and Family Services	Endoscopy	15/12/2017	Departmental risk assessment	9	As a result of the JAG visit on the 29th August 2018, the visiting assessment team's made the decision to defer awarding the Endoscopy Unit with accreditation for 6 months. As a result of this decision, the Trust/Endoscopy Unit has six months from receipt of the official Report to meet any key actions required before the cut off date in order for accreditation to be awarded. There were 18 Key actions that were identified form the report There is a risk that all the actions may not be met which may result in accreditation not be awarded to the Endoscopy Unit. These action relate to various IT issues inaccurate date collection, insufficient IT systems to support the Service, HAL data base not NEDS and JETS compliant, aspects of the Decontamination process not clearly auditable. Booking processes need consideration and action plans.	Will probably recur, but is not a persistent issue	Moderate	12	[27/06/2017 15:32:49 Henry Wilding] Miss Chave laising with Mark Newton (IT) to confirm what JAG requirements are and how in house system can be adjusted to meet these needs	28/09/2018	28/08/2018	Phillips, Lisa	Directorate Management Team Meeting	31/01/2019	2	Specialist Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Will discuss with Miss Chave to see where we are with this process for update.	31/01/2018	28/08/2018	Phillips, Lisa						
										Delays were escalated to Exec Team by DMC. Head of IT involved. Currently trialling system with fabricated data. HSC/LP to keep DMC informed of progress at Endo DMC meeting.	28/09/2018	28/08/2018	Phillips, Lisa						
										Post JAG visit 29 Aug, full responsibility for resolution to sit with IT. Discuss at Exec Performance review Sep ? escalation to Corporate Risk Register.	31/10/2018	23/10/2018	Montgomery, Alison						
										Working group established to work towards achieving all 18 actions identified on the JAG report. Please note that updates and are to be submitted to JAG in November 2018, January and March 2019	30/11/2018	30/11/2018	Stagg, Andrew						
										Update to be submitted to JAG Nov 18	30/11/2018	30/11/2018	Phillips, Lisa						
										Update to be submitted to JAG Jan 19	31/01/2019		Phillips, Lisa						
										Completed action plan and evidence to be submitted to JAG Mar 19	29/03/2019		Phillips, Lisa						
										Update on progress/issues to escalate to Execs via monthly CSFS Performance meeting	29/03/2019		House, Nicki						

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5705		Trustwide	31/01/2019	National guidance	12	Impact on the daily running of the hospital as a result of Great Britain's exit from the European Union. The consequence is that the resources (stocks and staff) could be depleted affecting service provision.	May recur occasionally	Major	12	Completion of risks assessments.	14/02/2019		Hyett, Andy	EU Exit Planning Group	14/02/2019	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Delivery of any new national actions.	14/02/2019		Hyett, Andy						
5706		Trustwide	31/01/2019	Directorate risk assessment	12	Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment.	May recur occasionally	Major	12	Continued dialogue with UHS.	01/04/2019		Hyett, Andy	Directorate Performance meeting	22/02/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										In discussion with other providers to provide an interventional radiology service.	01/04/2019		Hyett, Andy						
										COO, MD and CDs to meet to review clinical impact.	28/02/2019		Hyett, Andy						

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5414	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	15	There is a risk that the Trust does not achieve its financial plan in 2018/19. Due to the inability to deliver the CIP programme and planned activity levels alongside cost pressures. Could result in further regulatory action, the Trust entering special measures. The Trust needing to borrow additional cash and the impact on the reputation of the Trust.	Will undoubtedly recur, possibly frequently	Moderate	15	Trust currently developing plan to achieve revised control total, with additional savings/cost reduction schemes scheduled for Board approval 7th June. Trust Board approved plan - submitted to NHSI 20/6/2018. Update on additional savings going to 6th July Board of Directors.	31/07/2018	26/07/2018	Thomas, Lisa	Finance and Performance Committee	29/03/2019	10	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Trust following arbitration with Dorset, agreeing terms of data quality audit by 6th June. Trust Board agreed indicative contract - going to Finance & Performance Meeting 26/6/18	29/06/2018	26/07/2018	Thomas, Lisa						
										Year end forecast to be completed by the end of Q1 identifying key risks to financial position	24/07/2018	24/07/2018	Thomas, Lisa						
										Close scrutiny of savings programme and directorate financial performance monitored monthly, with recovery plans for areas projecting overspends.	31/03/2019		Thomas, Lisa						
										LT to have a discussion with commissioners on support to the Trust achievement of the revised control total. LT to discuss with Wiltshire CFO on what support can be provided.	31/08/2018	15/08/2018	Thomas, Lisa						

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5360	Corporate Development	Information Technology	28/02/2018	Data Protection	15	On Friday 12 May 2017, a global ransomware attack, known as WannaCry, affected a wide range of countries and sectors. Although WannaCry impacted the provision of services to patients, the NHS was not a specific target. There is a significant risk that Salisbury NHS Foundation Trust could potentially be hit by a rogue cyber attack or ransomeware attack in the not too distant future. This could result in IT systems being shut down, compromising patient care which will result in lost revenue. Even the most robust information security and disaster recovery plan is never failsafe. At this present moment in time SFT will be unable to obtain cyber security and ransomeware insurance as it is unable to demonstrate that all appropriate organisational and technical measures are in place to prevent the Trust IT infrastructure being breached. Data breach insurance generally covers incidents including and not limited to: *Forensic investigations *Legal advice/assistance *Public relations *Specialist contractors *Revenue protection Response to a data breach as a result of actions by an employee, contractor or external party such as a hacker - includes physical theft of data on paper or digital media. Time used in remedial actions directly related to the breach. Costs incurred through dealing with third parties i.e. hosting companies. 25/05/18 Risk ownership transferred from LA to BN. About to go out to tender for new anti virus software. This will include Ransomware software. Once installed this risk can be closed. Funded from capital - 7955C0 30/08/18 Tender complete. Order placed. Installation planned to complete by end November 2018 3/12/18 Order stopped. Now being re-raised, Complete by end February	May recur occasionally	Catastrophic	15	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	10/10/2018 28/02/2019	14/12/2018	Noble, Bob Noble, Bob	Information Governance Steering Group	28/02/2019	9	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development

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5364	Quality Directorate	Trustwide	01/03/2018	Trustwide risk assessment	16	Failure to achieve required ward nursing establishment with the following implications: Quality and safety concerns at ward level Poor patient experience High agency expenditure (financial risk to the Trust)	Will probably recur, but is not a persistent issue	Major	16	Domestic recruitment campaigns	30/04/2019		Wilkinson, Lorna	Trust Board	28/02/2019	12	People	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Overseas recruitment campaigns.	30/04/2019		Wilkinson, Lorna						
										Skill mix review x 2 per year	30/04/2019		Wilkinson, Lorna						
										Retention workstream to be completed	30/04/2019		Wilkinson, Lorna						
										Participate in NHSI collaborative for enhanced care.	31/12/2018	20/12/2018	Wilkinson, Lorna						
										Development of microsite	31/10/2018	29/06/2018	Wilkinson, Lorna						
										Develop apprenticeships and Nursing associate opportunities to broaden access into nursing	30/04/2019		Wilkinson, Lorna						
										Continue full recruitment of Nursing Assistant staff	30/04/2019		Wilkinson, Lorna						
										Closed as not applicable to this risk (Continue to ensure governance processes as listed within controls are embedded and influencing clinical practice, cleaning and antibiotic stewardship.)	01/04/2019	02/05/2018	Wilkinson, Lorna						
										Twice daily staffing review using safe care and roster data.	30/04/2018	30/04/2018	Hyett, Fiona						

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										Procurement agency staff at tier 1 rates only.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Review and consider threshold of care whilst maintaining safe patient services.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Tight control of agency and specialing.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Recruitment and retention initiatives eg introduction of automated exit questionnaires, career clinics for nurses and transfer process.	30/03/2018	29/05/2018	Hargreaves, Paul						
										Review rosters and job plans.	01/04/2019		Blanshard, Dr Christine						
										Look to partnerships with other Trusts to cover hard to fill posts. Have joined 'Clinicians Connected' and Locums Nest collaborative bank. STP Workforce strategy in development - recruitment stream.	01/03/2019		Hargreaves, Paul						
										Review of loss making clinical activities predominately supported by locums as part of business planning.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Launch overseas recruitment and more focussed recruitment in the UK.	30/03/2018	02/05/2018	Wilkinson, Lorna						
										Review & update (if appropriate) financial section of business case template for the appointment of medical staff.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Transitioning work with Army - making links with the groups moving back onto the plain - promoting careers at Salisbury with Army spouses	31/12/2017	25/01/2018	Holt, Sharon						

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5107	Organisational Development and People	Trustwide	27/03/2017	Trustwide risk assessment	12	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care. The impact of this effects staff morale and is unsustainable for the existing workforce if not addressed. Patient safety is at risk with gaps in substantive clinical workforce and cost of workforce increases over budgets. NHSI control total will be at risk. of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. Identified specialities are not recruited to establishment and therefore there is a reliance on a temporary workforce such as bank and agency. This has an impact on reputation, quality and financial aspects of the organisation. Posts identified include specialist Medical Posts (i.e. Dermatology, Community Geriatricians, Gastroenterology, Opthalmology) where this is a national recruitment problem and nursing post (particualrly medicine) where this is a supply problem	Will probably recur, but is not a persistent issue	Major	16	Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning	29/09/2017	25/01/2018	SALISH	Finance and Performance Committee	01/03/2019	12	People	Finance Committee, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Use of head hunting agencies to secure medical locums	31/03/2017	05/04/2017	Hargreaves, Paul						
										Monitoring agency usage via 'Reducing Agency Spend' group.	31/03/2017	05/04/2017	Wilkinson, Lorna						
										Monitoring of vacancies	31/03/2017	05/04/2017	Hargreaves, Paul						
										'Branding' of Salisbury to promote reputation.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Use of other medias including social media (Facebook and Twitter) to promote Trust	31/03/2017	05/04/2017	Hargreaves, Paul						
										Liaison with University to assess and promote student experience to ensure students consider SFT a positive place to work.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Working with training institutions to raise the profile of Salisbury and attendance at careers fairs such as university or national.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Recruitment initiatives such as 'refer a friend', European Recruitment, job fairs	31/03/2017	05/04/2017	Hargreaves, Paul						
										Implementation of a collaborative medical bank through Locums Nest.	01/05/2018	29/05/2018	Holt, Sharon						

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										To develop additional international recruitment pipeline by attending events in Australia and the UAE during 2018. Recruitment would be direct hire therefore saving the Trust an agency recruitment fee.	31/03/2019		Holt, Sharon						
										Develop "grow our own" approach for hard to fill vacancies.	31/03/2019		Holt, Sharon						
										Develop the use of apprenticeship roles within the Trust.	31/03/2019		Holt, Sharon						
										Maximising the use of 'Locums Nest' as a shared Medical Staff bank.	31/10/2018	16/10/2018	Blanshard, Dr Christine						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning, introducing stay conversation, 100 day survey and staff transfer scheme (repeat of previous action - re-opened).	01/03/2019		Holt, Sharon						

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February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5704		Trustwide	31/01/2019	Directorate risk assessment	16	The inability to provide a full gastroenterology service due to a lack of medical staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed.	Will probably recur, but is not a persistent issue	Major	16	Ongoing recruitment drive.	01/04/2019		Clarke, Lisa	Intensive Support Meeting	22/02/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019		Clarke, Lisa						
										Continuing insourcing of private provider to endoscopy.	01/04/2019		House, Nicki						
										Quantification and mitigation of the risk to bowel scope.	01/04/2019		House, Nicki						
										Tender for elements of the Gastroenterology service.	01/04/2019		Stagg, Andrew						
										Monthly update to F&P Committee and CGC.	01/04/2019		Hyett, Andy						

Corporate Risk Register
February 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4571	Facilities	Estates	17/06/2016	Other assurance not listed	12	[17/06/2016 18:27:00 Terry Cropp] Potential risk of failure of sterlisers, washers and associated plant and equipment used to sterlise equipment for the Trust and external customers. 03-04-2018 SDU are still operating on site within the existing facility (Level 2 Sector 3) and utilising the existing equipment (Autoclaves, Washers & AER's), this equipment is end of life, and a new facility was due to be operational July 2018. The risk of the failure of this equipment and or it being deemed not safe to use (failure of insurance inspections) is significant. One of the 5 x Autocalves is currently 'out of service' and requires major welding to enable a subsequent insurance inspection, there is a risk that this machine will not pass inspection due age (16+ yrs old) Note Autoclaves 1,2,4 + 5 are 18 years old, two of which are due insurance inspections in September 2018. At SSL July 2018 Board meeting decision taken to repair (cahmbers only) x 3 Autoclaves (Numbers 1, 2 & 3). This will enabel pressure tests and re-certification of vessells for insurance inspection. Options being explored for new AER's, a report to be produced by Steris for the August SSL Board meeting. Update 30th August 2018. Ancillary equipment that should also be covered by thsi risk should include the Dry Storage Cabinets. These units are used to store / hold the flexible endescopes after they have been processed by the AER's. These are loacted in Endescopy, Main Theaters and DSU. This equipment is circa 10 years old and is critical to the delivery of the Endoscopy service at SFT. Update January 19- Autocloave number 1 has a new jacket but unable to put into service due to faults. Relying on 3 autoclaves in use. Awaiting confirmation of status of repairs required.	Will undoubtedly recur, possibly frequently	Major	20	Refurbishement of 3 x Autoclaves	31/01/2019		Cropp, Terry	Not known	31/01/2019	6		Trust Board (Corporate Risk Register)	Chief Operating Officer
										SSL looking at options for the replacement of the AER's as instructed by the SSL Board, a report with the options and costs will be presented at the October 18 SSL board meeting.	28/02/2019		Cropp, Terry						
										Replacement of 1 x Autoclave, as an interim measure prior to the refurbishement of the new facility.	28/02/2019		Cropp, Terry						

Corporate Risk Register Summary – January 2019

Risk Score Key

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

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Jan 18	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Target
Risk Detail					**Score Trend**							
Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do												
5397	Inability to recruit enough nurse a decision has been taken not to open the additional medical beds	Chief Operating Officer	Apr 2018	20			20	16	16	16	12	9
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population												
3322	Genetics National Reconfiguration	Medical Director	Aug 2013	12	8	8	6	12	12	12	9	6
4808	Vascular surgery provision	Chief Operating Officer	Sept 16	16			16	15	9	9	12	3
5007	Endoscopy Unit JAG accreditation deferred for 6 months to address 18 key actions	Chief Operating Officer	Nov 18	9						12	12	2
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered												
	No risks to note											

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Jan 18	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Target
Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm												
5384	Inpatient fall resulting in harm; increasing frail population	Director of Nursing	Apr 2018	12		12	12	12	12	12	12	8
4107	Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients	Chief Operating Officer	Sept 2015	12	9	9	9	9	9	9	9	6
5577	Risk to patient safety due to overcrowding in ED (NEW RISK)	Chief Operating Officer	Nov 18	15						15	12	10
5516	Increase in emergency attendances exceeding the Trust's capacity to respond	Chief Operating Officer	Nov 18	16						16	16	9
5540	Potential impact on Trust's internal governance standards from new external HSIB investigation processes	Director of Nursing	Nov 18	6						6	6	2
5607	Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing (NEW RISK)	Director of Nursing	Oct 18	12							12	6
5704	The inability to provide a full gastroenterology service due to a lack of medical staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed (NEW RISK)	Chief Operating Officer	Jan 19	16							16	8
5706	Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment (NEW RISK)	Chief Operating Officer	Jan 19	12							12	8

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Jan 18	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Target
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams												
5107	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care	Director of OD & People	Apr 2017	12	16	16	16	16	16	16	16	12
5364	Failure to achieve ward nursing establishment	Director of Nursing	Mar 2018	16		20	20	20	20	20	16	12
5530	Consultation on wholly owned subsidiary proposal	Director of Finance	Sept 18	15					15	10	10	4
Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources												
5326	Review, PACS, POET, Lorenzo, WinDip & Paper Records	Director Corporate Dev	Dec 17	6			9	9	9	9	9	4
5396	Potential non delivery of CQUIN schemes	Director of Finance	Apr 18	16			12	12	12	12	9	6
5415	Unable to fund all capital expenditure requirements	Director of Finance	May 18	12			12	12	12	12	12	12
5414	Trust does not achieve its financial plan in 2018/19	Director of Finance	May 18	15			15	15	15	15	15	10
5480	Control of the quality of information submitted externally	Director Corporate Dev	July18	12				12	12	12	12	6
5553	Failure of the SUS/SLAM reconciliation process	Director Corporate Dev	Sept 2018	15					15	10	10	5

5487	Subsidiary financial performance and risk to SFT financial position	Director of Finance	Nov 2018	12						12	12	9
5360	Risk of cyber attack	Director of Finance	Nov 2018	15						15	15	9
5705	Impact on the daily running of the hospital as a result of Great Britain's exit from the European Union The consequence is that the resources (stocks and staff) could be depleted affecting service provision (NEW RISK)	Chief Operating Officer	Jan 2019	12							12	8