Date risk added	Division	Service	Divsion Risk Owner		Where risk identified / lead person		What Can Go Wrong / How Bad / How Often	Current grading			Action to be taken				Following your action what will the grading be? Target Grading			What has happened since you identified the risk		
Date risk added	**Division**	**Service**	**Divsion Risk Owner**	**Reference**	**Source (eg assessments, key targets etc)**	**Divisional Responsibility & Designated Lead**	**Summary risk description (specific points) (What could go wrong)**	**Impact**	**Likelihood**	**Current risk score /rating**	**Summary of existing control measures to manage the risk**	**Summary of planned actions, including deadlines**	**Resources to implement e.g. (financial, staff, equipment) & funding source**	**Specific date of interim review**	**Impact**	**Likelihood**	**Target risk score and rating**	**Progress to date (Enter here specific details of how the evidence of actions to manage the risk are progressing and dates of when this was updated)**	**Movement (increased, reduced or the same)**	**Quality Domain**
Dec-11	Women, Children and Families	Health Visiting	Maggie Buckell, Director of Operations	N/A	Recruitment program, experiential.	Sam Page, Head of Universal Children's Services	If we are unable to recruit, train and retain health visitors we will be unable to deliver our New Birth Visit KPI, provide assurance to the Board regarding the management of child protection and deliver the government target of increased HV numbers.	5	4	20	HV workforce strategy addresses: 1. Recruitment 2. Retention 3. Training 4. Practice development.	Actions include rolling recruitment programme, marketing and communications, new career development pathways and expansion of the HV training programme. We expect that most HV expansion will happen through the development of new training places in partnership with NHS London and the Educational Institutions starting in Sept 2012. Other actions to maintain and expand the workforce will continue to be developed.	Infrastructure to support and expand workforce	Sep-12	5	2	10	**August 2012 -** see actions.	→	n/a
Dec-11	Women, Children and Families	Child Protection	Bronagh Scott, Director of Nursing and Patient Experience	N/A	Child Protection Committee	Maggie Buckell, Director of Operations	If the information on the scorecard does not incorporate accurate information from across the trust (for example training levels) we will not have adequate assurance that child protection is being managed adequately. For example if staff have not attended training for CP and are therefore not aware of the policy accurate referrals will not be made and children may suffer as a result.	5	4	20	The Training Needs Analysis is complete. Each post on the Whittington Health staff list (4000+) has been allocated to a competency level as set out in The Intercollegiate Document for Safeguarding Children and Young People (DOH). The new Training Policy (approved by Child Protection Committee and Executive Committee) also clearly signposts staff to the correct level of child protection training. There is a planned co-ordinated response between Learning and Development and Information Departments to work in collaboration with the Named Nurses to develop a system which can accurately record and report data	Islington and Haringey Community Health Trusts had specific systems for collecting and recording data. Accurate data has been recorded for uptake within Children's services of child protection training. Children's services managers are also tasked with monitoring uptake and attendance of their staff and can evidence attendance through existing data sets. This level of recording needs to replicated with adult and acute services within Whittington Health and with junior doctors on rotation. Named Nurse for Child Protection working with Learning & Development for support to record existing data and future training centrally on ESR. There is a requirement that any future system put in place will be able to accurately record and audit training statistics throughout Whittington Health. Named Nurse for Child Protection has arranged a series of meetings with L&D to proceed with this action plan of migrating existing information from legacy organizations into one centralized ESR.	May require additional Admin support to maintain and update records of training until ESR issue	Sep-12	5	1	5	**August 2012 -** see actions and controls. Review of ESR undertaken by the Director of People and presented to the Quality Committee July 2012. Self management of ESR being rolled out and update to go to the Quality Committee October 2012.	→	All
Mar 11	Women Children and Families	Maternity	Maggie Buckell, Director of Operations and Friedericke Eben, Divisional Director	N/A	Change in clinical care has resulted in an increase of dependency of both women and babies. This affects maternity, neonatal unit and special care baby unit	Jenny Cleary, Head of Nursing	If there continues to be high levels of dependency of women and babies within the unit, the unit may not be able to sustain a safe service.	5	4	20	Review of patient safety incidents Implementing the escalation policy Monitoring staffing levels Cohorting transitional care babies on the postnatal ward Project work ongoing within the area Increased visible leadership in the clinical area	Business case underway to expand the unit. Productive ward, maternity needs support with this Refurbishment required to accommodate the increased dependency of the women and babies Review skill mix Monitor sickness and absence Report on bookings and birth to go to EC in August 2012.		Sep-12				**August 2012 -** See actions	→	Safety
June 2012	Women, Children and Families	Maternity and theatres	Maggie Buckell, Director of Operations and Friedericke Eben, Divisional Director	N/A	There is only one obstetric theatre on labour ward. If a further theatre is required the women must be transferred to main theatre which takes 10 minutes.	Jenny Cleary, Head of Nursing	If the obstetric theatre is in use women must be transferred to the main theatre which results in a delay in decision to delivery time and depletes the staff mix on labour ward as staff need to transfer and remain in main theatre/recovery. This can also impact on trust wide theatre activity.	5	4	20	Skilled co-ordinator to manage complex working environment Maternity has a fully equipped theatre in main theatres Local process for transferring the woman and staff to theatres Incident reporting and investigation	Review skill mix to include portering services Monitor sickness and absence Building of a second theatre and recovery beds on the labour ward is included in the refurbishment plans Use of the second theatre is monitored monthly		Sep-12	5	3	15	**August 2012** - See actions.	→	All

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February 11	Women Children and Families	Maternity	Maggie Buckell, Director of Operations and Friedericke Eben, Divisional Director	N/A	NHSLA Corporate risk register	Jenny Cleary, Head of Midwifery	If we fail CNST level 3 in 2012/13, then this will have financial implications	4	5	20	Continue with Work Programme for Level 2 requirements. Detailed schedule of work being developed to work toward Level 3.	Detailed schedule of work being developed to work toward Level 3. McKesson EPR will aid in data collection once it has been rolled out and embedded in documentation culture. Funding is available for IT midwife to project manage the implementation Funding allocated for a guideline and audit midwife.		Sep-12	5	1		**August 2012 -** Actions in progress. Risk increased following review at divisional level.	↑	All
Nov-11	Trust wide	Trust wide	Maria Da Silva, Chief Operating Officer & Richard Martin, Director of Finance	N/A	Trust Operational Board	Richard Martin, Director of Finance	2012/2013 - If the CIP programme is not achieved then NHS London will not invest additional financial capital and the organisation will not achieve Monitor financial tests to become a Foundation Trust.	4	4	16	Divisional Boards and management meetings Executive Committee Trust Board Weekly CIP Board to increase level of monitoring and mitigation of risks; slippage identified reported to the Finance and Development Committee	Project plans with deadlines underway; received weekly at CIP Board CIP Programe Manager has now been recruited (3rd September 2012). PIDs being finalised for all CIPs for 12/13, 13/14 and 14/15 by the end of September 2012.		Sep-12	3	3	9	**August 2012 -** see actions	→	All
Apr-11	Human Resources	Trust wide	Margaret Boltwood, Director of HR	09/162	Executive Committee and legacy risk registers (all)	Charlotte Johnson, Head of Education, Learning and Development Services	If staff across the Trust have not attended mandatory training then they may not be aware of the correct policies and procedures to be followed.	4	4	16	All directors have agreed to prioritise ensuring that staff are released and do attend mandatory training provided. Director of HR and Director of Facilities have prioritised additional provision of relevant training for staff.	ICO Wide review of Mandatory and CPD to be conducted to review thresholds for compliance. In April 2012 staff will receive a training record for mandatory training to be completed in 2012/13. As at 31 March 2012 70% of staff are up to date with their mandatory training. Staff are receiving their individual training records in May 2012 to enable them to plan their training requirements ongoing. Training compliance rates continue to be monitored on a month basis by divisional and Operations Board. August 2012 Updated information and publicity sent out to all staff. Meetings in place with specialist expert subject trainers to introduce more robust system for recording face to face training.		Sep-12	4	2	8	**August 2012** - See actions	→	Clinical Effectiveness

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Apr-11	Trust wide	Trust wide	Matthew Boazman, Director of Operations	10/169	Information Governance	Phil Ient, Director of Estates and Facilities	If there continues to be inadequate storage space for legacy and archived paper records we will not be compliant with legislation.	4	4	16	Information Lifecycle Policy Approval to develop a managed records storage facility on site.	Develop a managed records storage facility on site. Records management project established under leadership of Matthew Boazman with P&P project management input.		Sep-12	4	2	8	**August 2012** - see actions.	→	All
Apr-11	Trust wide	Trust wide	Yi Mien Koh, Chief Exective	N/A	QIPP Programme	Margaret Boltwood, Director of HR	If there is inadequate investment in the workforce then the CIP programme will not be achieved. This will also impact negatively on staff morale. There is a potential to impact negatively on patient experience and quality of care	4	4	16	Trust Board Trust Operational Board Executive Committees Workforce Development Strategy Workforce strategy and Staff Engagement Programme agreed by Trust Board April/May 2012.	In addition action being developed to enhance staff engagement. August 2012 Programme of engagement of roll out of organisational Values in place.		Sep-12	3	3	9	**August 2012 -** See actions	→	n/a
Apr-11	Nursing and Patient Experience	Trust wide	Bronagh Scott, Director of Nursing and Patient Experience & Celia Ingham Clark, Medical Director	N/A	Serious incidents and incidents Service risk registers	Bronagh Scott, Director of Nursing and Patient Experience & Celia Ingham Clark, Medical Director	If there continues to be poor and inconsistent record keeping this may lead to sub optimal care.	4	4	16	Record keeping policy Training Audits .	Training on record keeping and care planning for Nursing staff. Audit of nursing record keeping as part of the senior nurse visible leadership audit programme.Trust wide audit of record to be undertaken as part of the annual Trust audit cycle 2011/12. Audit of nursing record keeping to be incorporated into annual audit cycle by Clinical Audit and Effectiveness Committee for 2013/14 Electronic health record due for first part of implementation in November 2012. Emails sent to all training grade doctors Feb 2012 to remind them of their responsibilities in record-keeping and filing. April 12 - Audit of Nursing care planning conducted by VLT in March 2012 - verbal reports highlighted improvements in most areas - awaiting audit		Sep-12	4	2	8	**August 2012 -** memo sent to all Nurses and AHPs in May 2012 outlining responsibilities re record keeping. Ad hoc audit in August 2012 highlighted improvements, areas for improvement being raised with ward sisters, matrons and staff.	→	All
Aug-11	Nursing and Patient Experience	Governance	Bronagh Scott, Director of Nursing and Patient Experience	N/A	Executive Committee 18.04.2011	David Williams, Assistant Director of Governance	If there is a lack of clarity for reporting arrangement for governance during transition to ICO and organisational restructuring, then this could lead to a failure in reporting of risks through the organisation in a timely manner.	4	4	16	Reporting mechanisms in place to all Governance Committees, data/information and reporting processes are being aggregated until unified systems are in operation. All committee structures have representation from Community and Hospital services to ensure the correct flows of information. Quarterly aggregated report on claims complaints, litigation and PALs presented to Quality and patient safety Committee Quarterly. BAF and corporate risk registers being reviewed monthly at Executive Committee and bi-monthly at Audit Committee and quarterly at the Trust Board. Community Quality Indicators reviewed montly at Quality Committee (began March 2012).	Further development of Quality and Patient Safety Dashboard required to include community Indicators – being developed by Performance and Planning directorate for presentation to Quality and Patient Safety Committee in March/April 2012. Further review and development of BAF to refine and prioritise risks. Deep dive into high risk areas to conducted by Audit Committee on 7th March 2012. Actions to be agreed to address concerns identified at deep dive. NHSLA Level 2 action plan being progressed. Funding agreed for additional support to take this work forward. Terms of Reference for all feeder committees are under review based on NHSLA criterion, target date for completion and approval by Quality and Patient Safety Committee April 2012. April 2012 - Datix Integrated Reporting for incidents, complaints, risks,	Staff/ Financial	Sep-12	4	1	4	**August 2012 -** Whittington health has agreed to be a test site for the National Quality Dashboard. Trust integrated dashboard under construction. Deep dive into risk areas on BAF planned for Sept 2012 Audit Committee. BAF revised by Executive Committee July 2012 following feedback from Deloittes. Risk register and BAF to be uploaded to Datix in September 2012. Action plans developed to address feedback from BGAF and MQF.	→	Safety

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Jan-12	Women Children and Families	Maternity	Maggie Buckell, Director of Operations	N/A	Change in clinical care has resulted in an increase of dependency of babies. This affects maternity, neonatal unit and special care baby unit	Jenny Clearly, Head of Midwifery	If there continues to be an increase of babies requiring transitional care babies then the unit cannot sustain a safe service	4	4	16	Datix incident reporting Cohorting transitional care babies on the postnatal ward Project work ongoing within the area Increased visible leadership in the clinical area	Productive ward, maternity needs support with this Refurbishment required to accommodate the increased dependency of the women and babies Review skill mix Monitor sickness and absence		Sep-12				**August 2012 -** See actions	↔	Safety
August 2012	Women, Children and Families	Maternity, labour ward recovery	Maggie Buckell, Director of Operations	N/A	Risk assessment	Jenny Clearly, Head of Midwifery	If post operative and high risk patients do not receive 1:1 care this may have an adverse impact on patient safety and patient experience.	4	4	16	Pull staff from current unit establishment/senior team when possible. Otherwise use bank/agency.	To be agreed.		Sep-12				**August 2012** - NEW RISK	**NEW RISK**	All
Oct-11	Surgery, Cancer and Diagnostics	Pathology	Director of Operations, Matthew Boazman	N/A	Risk assessment	Mary Jamal, Deputy Director of Operations	If we are unable to meet the requirements of the NPSA alert 'NPSA SPN 14 (2006) – Right blood, right patient and Never Events 2011/12 (DOH) – ABO incompatible blood transfusion we may be deemed not compliant and this may lead to an adverse incident . Manual traceability and blood component cold chain audit trail make it difficult to meet the Blood Safety and Quality Regulations (2005).	5	3	15	Trust wide Blood Policy and Clinical Guidelines. Trust wide blood transfusion training and competencies. Pathology Users Guide. Laboratory automatic requesting of confirmatory samples for the blood grouping of new patients to reduce the risk of Wrong Blood In Tube (WBIT) giving rise to an ABO incompatible blood transfusion	To implement a vein-to-vein blood tracking IT system to: 1) Protect patients from ABO incompatible transfusion. 2) Automatically monitor all blood component activity (time out of temperature control). Actions to be implemented 2012/13 April 12 - Patient Safety System - Vein-to-Vein: Business case reviewed and approved by Hospital Transfusion Committee (April 24th) and by the Drugs & Therapeutics Committee (May 10th). Approved by the Divisional Board on June 27th with the recommendation to review risk rating (risk rating reduced as a result). Business case to be presented in October 2012 time and to include sector position and documents from other Trusts on the matter.		Sep-12	5	1	5	**August 2012 -** Likelihood reassessed and reduced due to controls in place.	↓	Safety
Apr-11	Integrated Care and Acute Medicine	HMP Pentonville Healthcare	Carol Gillen	373	Legacy risk register (Islington Community)	Tony Madden	If the governance arrangements (including accountability and responsibilities) for the three partner agencies providing healthcare are not clarified this may lead to: - Fragmented working arrangements - An adverse impact on decision making (creating further risk including clinical) - Delays in resolving risks and issues	4	4	16	Workload reviewed and prioritised as part of day to day management of activity.	Work underway with representatives from Barnet, Enfield and Haringey Mental Health Trust and Camden and Islington Foundation Trust to review and clarify the governance arrangements. Assistant Director of Governance in the process of drafting governance arrangements for consultation.		Sep-12				**August 2012 - NEW RISK (escalated by ICAM)**	**NEW RISK**	All

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Feb-11	Trust wide	Trust wide	Julie Andrews, Consultant in Medical Microbiology and Virology Director of Infection Prevention and Control	N/A	The isolation rooms on Mercers and Nightingale do not operate independently of each other. They only operate under negative pressure if all the doors are closed, as soon as one room is opened this affects the pressure in the other rooms.	Phil Ient, Director of Estates and Facilities	If there is a need to isolate a patient in an environment of negative pressure (enhanced isolation) there is a risk this will not be met which may lead to cross infection.	5	3	15	Nurse patients in ITU where enhanced isolation rooms are available.	Phil Ient and Julie Andrews discussing further the need for additional enhanced isolation rooms (this needs to be tested) before a business case is started (September 2012).		Sep-12				**August 2012 -** The situation remains that the need for additional isolation rooms has still to be tested before a business case is developed to seek funding	↔	Safety
Mar-12	Estates and Facilities	Trust wide	Phil Ient, Director of Estates and Facilities	N/A	North Central London (NCL) due diligence audit of statutory compliance with premises regulation reflects potential significant areas of non compliance (particularly in relation to water regulations).	Phil Ient, Director of Estates and Facilities	If we do cannot obtain assurance from North Central London that we are compliant with regulations for premises (particuarly water regulations) then we may be operating outside of legal and governance requirements. This could potentially lead to harm and is also a reputational risk.	5	3	15	There is nothing to suggest that currently there are issues of general non compliance across premises that formed part of the Haringey and Islington Community. However, efforts to confirm that L&S compliance is being effectively managed have failed. In essence this means that whilst there may be full compliance, there is no means of knowing if there is or not.	NCL have provided a due diligence audit of statutory compliance for half the community premises (Islington) which shows significant gaps and areas of concern: - Meetings are being held fornightly with NCL where the issues are being discussed. - Phil Ient, Director of Estates and Facilities has escalated the concerns to the NCL Head of Estates and Facilities to agree necessary action (actions to be agreed by the end of March 2012). - If the deadlines is not met and actions are not agreed this will be escalated to the Chief Executives for Whittington Health and NCL. - At premises level a regime of flushing and testing is to be established. - Systems survey to be undertaken (cost with NCL).		Sep-12	5	1	5	**August 2012 -** The situation remains that NCL have provided a RAG rated risk assessment matrix that illustrates compliance across L&S issues. The veracity of this information has not been tested.	↔	N/A
May-10	Women Children and Families	Maternity	Maggie Buckell, Director of Operations	10/171	Maternity Clinical Risk Management Corporate risk register	Phil Ient, Director of Estates and Facilities	If the lift outside LW breaks down, then this may lead to a delay in transfer of women to the labour ward in an emergency.	5	3	15	There is a second lift down the corridor. If the lift breaks down, then the birth centre must be closed for patient safety Follow the escalation policy Lift maintained in accordance with legal standards by Otis	Review lift failure protocol in place to deal with lift failures The installation of a new twin lift core and stairs has been approved and funded. Installation due to start in December 2012. In the meantime the enhanced maintenance remains in place.		Dec-12	4	3	12	**August 2012 -** installation plans due to start December 2012.	↔	Safety
April 2012	Trust wide	Point of Care Testing (all clinical areas)	Matthew Boazman, Director of Operations	N/A	Risk assessmentrergarding point of care testing has identified: Lack of comprehensive training/password sharing/incorrect patient identification/poor sample quality/lack of quality assurance/lack of audit trail/over reliance on ward and department staff to maintain and calibrate devices and lack of back up.	Mary Jamal, Deputy Director of Operations and Jayne Fowler, Pathology Quality Manager and Marie Parsons, Consultant Biochemist	If there continues to be inadequate processes for the use of point of care testing this may lead to incorrect results; lack of, inappropriate or delayed treatment; tests being carried out or recorded in relation to the wrong patient and faulty devices.	5	3	15	Bayer BGM - training and competency procided at induction and on an annual basis. Blood gas - training provided at induction sessions. Abbott BGM - training provided at induction sessions.	1. No training or competency programmes in place for POCT other than those listed in the controls. 2. BGA/Hb analysers are password protected yet password sharing continues. Rollout of the bar-coded staff ID badges has been suspended, a business case will now be submitted to move forward with the rollout of these which will aid / reduce the password sharing. The business case and risk assessment is due to go to the executive committee for approval. Feedback still awaited from Director of Estates and Facilities. 3. Moving forward with the implementation of the networked blood glucose monitors (despite the lack of centrally issued bar-coded ID badges), this will allow only trained users to access the devices, have quality control lock out, i.e. QC will need to be done every 24 hours otherwise the device will not be available for use, results will be available electronically, all these combine to form a complete audit trail. this will improve clinical governance and help achieve action plans devise at an operational level. A requirement for compliance with accreditation standards. The Me		Sep-12	5	2	10	**August 2012 -** See actions.	↔	All
Apr-11	Trust wide	Trust wide	Bronagh Scott, Director of Nursing and Patient Experience	08/113	National guidance. National & Local patient surveys and legacy risk register (Whittington Hospital)	Jennie Williams, Assistant Director of Nursing and Patient Experience	If there is adverse feedback from patient surveys and we fail to respond this will impact on the patient experience and the reputation of the Trust.	4	3	12	Rolling programme of Complaints Training for managers and staff. Visible leadership of senior nurses including Matrons Conversations with patients and staff. Process for patients to provide real time patient feedback in place in wards and departments. Trust Twitter site in place for real time feedback. Revised Trust Complaints process. Patient safety walkabouts for senior executives and Non Executives. Patient Experience Steering Group with Divisional operational representation has been re established. Patient Experience Steering group has been reestablished and meets 6 weekly with representation from all divisions. A number of staff sessions on improving pateint experience conducted in May and June 2012. Three priority areas identified for focussed improvement strategies - ED, Maternity and OPD.	Patient Experience strategy to be developed and approved by the Patient Experience Steering group by end of December 2012. Targets for use of Patient Experience Trackers by each ward and department being developed to be completed and shared with Departments and Divisions by end of September 2012. Inpatient Patient satisfaction Report presented to Quality Committee in July 2012. Actions to be agreed and presented by November 2012. OPD satisfaction survey completed and results received; inpatient satisfaction survey results currently being collated. Deep Dive into Out-patients took place in July 2012. Survey results (which were positive) and action plan presented to Trust Board workshop in July 2012. Action plan endorsed.		Oct-12	3	3	9	**August 2012** - See controls actions	↓	All

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Apr-11	IT	Trust wide	Yi Mien Koh, Chief Exective	N/A	BAF	Glenn Winteringham, Director of IT	If IT systems and infrastructure are inadquate then a number of key targets for the Trust will not be met for example if staff cannot access e-learning this will result in a failure to deliver mandatory training programmes.	4	3	12	Standardised IT infrastrcuture across the hospital. Non-standardised across the community. Plans to novate IT support contract from NCL to WH ICO underway to ensure direct management of service provider 2e2. Regular service review meetings in place to improve the service to community.	WH ICO Integration Board established for IT infrastructure. Design documents for the network and servers\applications completed; desktop and telephony in development.		Oct-12	3	3	9	**August 2012 -** Network links ordered with to complete installations by the end of September. Once the network links in place, the aim is to migrate community IT services out of community data centres and host in the hospital data centres for improved service\reduced costs by March 2013. The aim is also to refresh all community desktops with a new single standardised WH ICO desktop image before implentation of the Electronic Patient Record project phase 2.	→	All
Apr-11	Trust wide	Trust wide	Maria DaSilva, Chief Operating Officer	N/A	BAF	Divisional Directors, Directors of Operations and Margaret Boltwood Director of HR	If there is a slow pace of integration for community and acute staff and services then there will be a delay in developing a cohesive culture of organisational learning which will impact on the quality of care and experience of patients. This will also impact on the Trust's ability to meet its financial targets and its application for Foundation Trust.	4	3	12	Delivered by integrated management structure Integrated Divisional Boards Transformation Projects (e.g. rotation of nurses between acute and community) Visible leadership (Board) Workforce Development Strategy Engagement Strategy Communication Plan	Workforce strategy and Staff Engagement Programme agreed by Trust Board April/May 2012. In addition action being developed to enhance staff engagement. Employment of Head of Transformation to support transformation programme. Deep Dive re staff engagement planned for Audit Committee 13th September 2012. Weekly meetings of CEO with Divisional Directors and Directors of Operations.		Sep-12	3	2	6	**August 2012 -** See actions	↔	n/a
August 2011	Finance	Planning and performance	Fiona Smith, Director of Planning and Programmes	N/A	Executive Committee 03.05.2011	Ali Kapasi, Info Gov manager	If there was a non compliance with information governance requirements this would adversely affect CQC assessment and external IG compliance assessment.	4	3	12	Information governance policy. CQC assessment IG toolkit submission and report Parkhill internal audit review and report to Audit Committee IG report to Audit committee bi annually IG report to Trust Board annually	IG steering group meeting monthly IG action plan for 2012/13 developed and implementation underway Parkhill carried out internal audit of IGT in May 2012. Action plan developed to address the gaps identified. Reported to July Audit Committee Performance Manager and Information Governance post established in operations to lead on IG toolkit requirements in operations directorate. 9 month fixed term post established to add capacity to ensure action plan delivered.		Sep-12	4	2	8	**August 2012 -** see controls and actions.	→	n/a
Sep-11	Integrated Care and Acute Medicine	Trust wide	Matthew Boazman, Director of Operations	N/A	Risks associated with implementation of NPSA/2011/PSA/001 Part A (spinals)	Tim Blackburn	If the alert is not implemented within the required timescales we will be deemed non compliant. However there are risks in introducing medical equipment that has been inadequately tested.	4	3	12	Anaesthetists are the only clinicians who inject drugs via spinal needles. They are aware of a potential risk **IF** the wrong kit is brought into the Trust.	There are now at least five different replacement connectors that have been introduced onto the market, with almost no independent clinical trials published in peer reviewed journals, analysing efficacy and safety. Until adequate evidence is available from which to make a rational decision it is not deemed appropriate to make the change, and this is supported by all the anaesthetic professional organisations. There should be further research available from which to help make a decision later on this year (after September 2012)		Sep-12				**August 2012 -** see actions**.**	→	Safety
May 2012	Trust wide	Pathology Facilities	Matthew Boazman, Director of Operations and Phil Ient, Director of Estates and Facilities	N/A	Regular breakdown of autoclave. Risk assessment regarding contigency in the event of pathology autoclave breakdown.	Mary Jamal, Deputy Director of Operations	If there continues to be regular breakdown of autoclave this will result in inability to conduct sterilisation of infectious waste and laboratory equipment. Leading to: - accumulation of infectious waste - severely compromised laboratory function - transit of waste is through public areas within the hospital - inability to dispose of category 4 materials (rare)	4	3	12	Time of interval between pick up of waste, including category 3, by contractor -typically one week. Specialised waste bins in place for storage and subsequent removal of waste. This has significant financial cost considerations.	More regular waste retrieval will have significant economic impact. Several lines of laboratory reagent normally produced in-house would need to bought in at great expense. Equipment including filters for conducting environmental testing (such as endoscopy rinse water and tap water) would also need to be bought in. A replacement autoclave is needed as soon as possible. This is being taken forward by Estates. The autoclave has been working for the past week but requires constant checking.	Financial	Sep-12	?	?	?	**August 2012** - see actions	→	Safety
Dec-11	Corporate	Trust wide	Richard Martin, Director of Finance	N/A	Risk assessment	Directors of Operations and Directors of Departments	If we there is insufficient communication of the Bribery Act to staff or insufficient procedures in place to prevent bribery then we are at risk of prosecution.	4	3	12	Fraud Policy Hospitality Policy New Contracts including Bribery Act clause All procurement staff formally trained on implications of Bribery Act (funded by RFL trust)	Implementation of staff briefings so all staff know their roles and responsibilities in relation to the act (Counter Fraud Specialist, April 2012). Review of arrangements for contracting (July 2012). Review of effectiveness of Fraud and Hospitality Policies (audit programme April 2012)		Sep-12	5	1	5	**August 2012 - see actions**.	→	Safety
August 2012	Estates and Facilities	All clinical areas	Phil Ient, Director of Estates and Facilities	N/A	Safety alert	Debbie Hoar, Decontamination Advisor	There is a risk that invasive ultrasound Transducers are being/have been inadequately decontaminated between patients. This may be because the Manufacturers' guidelines are inadequate or because they have not been followed correctly.	4	3	12	All probes used in this way have a disposable cover (much like a condom). In some areas a draft SOP for decontamination exists or a local guideline detailing how cleaning should be carried out. In all areas some method of cleaning of the probe is in use.	Information gathering listing all devices and uses by mid September 2012 Assess risks of all devices depending on their use. Identify those requiring Mod/high level disinfection. By end of September 2012 Examine Manufacturer's decontamination guidelines for high risk devices and local cleaning policy/guideline. By end of September 2012 Identify those where increased level of decontamination is required. Ask users to write SOP for decontamination ratify at committee level. By end of September 2012		Oct-12				**August 2012** - NEW RISK	**NEW RISK**	Safety
Apr-11	Divisions	Trust wide	Divisional Directors	384	Community risk register	Directors of Operations	If there is inadequate support to manage disruptive and aggressive behaviour this may have an adverse impact on staff, particularly in community settings.	5	2	10	Conflict resolution training Managing Violence and Aggression policy. Panic alarms in clinics and health centres. Support and counselling services in place for staff who experience disruptive or aggressive behaviour.	None at present. Conflict resolution training part of mandatory training days.		Sep-12	3	3	9	**August 2012 -** see actions.	→	Clinical Effectiveness Patient Experience

Date risk added	Division	Service	Divsion Risk Owner	Reference	Source (eg assessments, key targets etc)	Divisional Responsibility & Designated Lead	Summary risk description (specific points) (What could go wrong)	Impact	Likelihood	Current risk score /rating	Summary of existing control measures to manage the risk	Summary of planned actions, including deadlines	Resources to implement e.g. (financial, staff, equipment) & funding source	Specific date of interim review	Impact	Likelihood	Target risk score and rating	Progress to date (Enter here specific details of how the evidence of actions to manage the risk are progressing and dates of when this was updated)	Movement (increased, reduced or the same)	Quality Domain
Apr-11	Divisions	Trust wide	Divisional Directors	382	Community risk register	Directors of Operations	If there are inadequate arrangements to manage lone working staff groups working outside of normal office hours, in the community and visiting patient homes may be adversely impacted.	5	2	10	Lone Working Policy	Outstanding risk regarding sharing information across services/professionals and other organisations.		Sep-12	3	3	9	**August 2012 -** see actions.	→	Safety Patient Experience
Apr-11	Nursing and Patient Experience	All clinical areas	Celia Ingham Clark, Medical Director	08/129	Incidents and legacy risk registers (all)	Helen Taylor, Chief Pharmacist	If staff fail to follow the drug administration policy this will lead patient safety incidents.	5	2	10	Prescribing policy Training Clinical Supervision Drug admin policy (updated Jan 2012) Ward pharmacists Audit of medicines administration and adherance t o policy conducted by senior Nurse Visible Leadership Team twice yearly. The requiremnet and expectation of all staff to follow policy emphaised at Trust induction sessions for Nurses Continous montoring of Datix incidents. Reports and active feedback to reporters from the medicine safety committee. Action plans formulated and monitored by medicine safety committee on a continous basis. 'Hypo boxes' now on all wards and training given. Regular medicine Safety Bulletins Two monthly datix summary report on medication incidents is presented at the Medicines Safety Committee. Follow up actions	Roll-out of electronic prescribing due for completion in Spring 2012. Joint project with rheumatologists to produce a bulletin to promote the safe use of oral methotrexate. Promote increased communication between pre-assessment and anticoagulant clinic teams. Antimicrobial pharmacist to clarify allergy recording protocol on admission. Divisional quarterly incident reports to include trust wide learning from medication incidents from Q2 2012. Action plan in progress for the extended list of NPSA never events.		Sep-12	3	2	6	**August 2012 -** Electronic prescribing now rolled out across the whole of medicine. Roll out throughout Surgery and theatres will be end of Sept beginning of October. All Junior doctors have been trianed on the system and this process has been set up with the deanery so that each new intake have their training on the system. System set up with risk managment to provide narrative and action on medicine incidents for divisional reports. Active reporting back to the individual Datix reporters on medication incidents and actions.	→	Safety
Mar 12	Women, Children and Families	Paediatrics	Maggie Buckell, Director of Operations and Friedericke Eben, Divisional Director	N/A	Non-compliance with NICE guidance and associated risk/ lack of resource to achieve full implementation. NICE have in recent months, published two guidelines: Food allergy in children and young people and Anaphylaxis (adults and children). Presently, the organisation is partly compliant with the food allergy guideline (compatible with current practice in secondary care but not in community/ primary care) and non compliant with the anaphylaxis guideline (paediatric aspects)	Dr Neeta Patel, Consultant Paediatrician, Miriam Tarkin, Paediatric Dietician and Sarah Crook, Clinical Governance Manager	If anaphylaxis guidance is not implemented there is a risk of a child having a further (potentially avoidable) anaphylaxis and death. If food allergy guidance is not implemented there is a risk of: 1. Anaphylaxis deaths due to incorrect diagnosis/inadequate management 2.Continued increase in unplanned ED admissions and inpatient admissions with allergic reactions/anaphylaxis. 3 Continued rise in incidence in nutritional deficiencies (rickets, anaemia) in food allergic children on exclusion diets 4. Continued increase in secondary care allergy referrals to paediatric/dermatology. Paediatric allergy waiting times currently 6 months. 5. Continued poor primary care management of infant allergic disease (eczema. food allergy) resulting in progression of the allergic march and more asthma attendances/admissions.	3	3	9	MDT clinic in secondary care (Allergy service only) Specialist allergy dietician for inpatients, outpatients and GP troubleshooting Nurse dietician follow up in hospital and community (to increase capacity	Planning in relation to anticipated numbers over next 12 months. Ultimate requirement subsequent to planning stage: More dieticians, community nurses and allergy trained doctors to comply with both RCPCH and National guidance including recommendations from NICE. Risk to be escalated to the commissioners as the trust is not commissioned to provide a full allergy service.		Sep-12				**August 2012 -** additional investment secured for allergy/asthma clinical services. 2.0wte additional nursing posts and 0.5wte allerfy dietician. Posts being recruited too Sept 12	→	Safety/Effectivenes s
Apr-11	Nursing and Patient Experience	Trust wide	Bronagh Scott, Director of Nursing and Patient Experience	07/24	DOH target and legacy risk register (Whittington Hospital)	Sue Tokley, Assistant Director of Nursing and Patient Experience	If we failure to reduce HCAI rates this may have an adverse impact on patient experience and the reputation of the trust.	3	3	9	Infection control rates monitored through Infection Control Committee, Divisional Boards and Quality Committee through weekly IC flash reports. Regular audits of hand Hygiene and infection control practices are carried out by both members of the IP&C team and departmental staff.	The Trust continues to meet defined targets for MRSA Bacteraemia and C Diff however the risk remains particularly given the changing method of testing for C Diff which has been introduced as mandatory in 2012.Targets for 2012/13 more challenging. C-Diff 21 cases and MRSA Bacteraemia - 1 case. We have had one MRSA post 48 hour bacteraemia so we are on target and cannot have another episode for the remainder of the mandatory year. We are below tragectory for CDT cases with 5 to date.		Sep-12	4	2	8	**August 2012 -** see actions.	→	safety

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Apr-11	Nursing and Patient Experience	Trust-Wide	Bronagh Scott, Director of Nursing and Patient Experience	08/05	Infection Control Cmte and legacy risk register (Whittington Health)	Sue Tokley, Assistant Director of Nursing and Patient Experience	If there is an inadequate number of isolation rooms and inappropriate use of isolation rooms this may lead to the spread of infection.	3	3	9	Introduction of LIPS to prioritise patients for isolation point prevalence audit to provide capacity/demand data quarterly. Electronic bed management system introduced. Any refurbishment on new building to take in to account isolation requirements. Infection control policy in place re. cohorting patients.	Actions include a post ward reconfiguration review. With some of the ward changes planned, there is likely to be a loss of the use of available single isolation rooms. Some of these rooms are en-suite, therefore toilet facilities will also be reduced.		Sep-12	4	2	8	**August 2012 -** see actions	→	Safety
Apr-11	Nursing and Patient Experience	All clinical areas	Celia Ingham Clark, Medical Director	08/128 & 09/148	Incidents NICE guidance clinical and legacy risk register (Whittington Hospital)	Celia Ingham Clark, Medical Directors and Heads of Nursing	If there is a failure to recognise and act on deterioration in clinical status of patient this may lead to patient harm.	3	3	9	Training - rolling programme. Deteriorating Patient teaching occurring through ILS / ALS / BLS training to all staff HELP course targeted to nurses and junior medical staff Clinical Supervision Part-time critical care outreach team SBAR introduced Continuous audit of out of critical care cardiac arrests being undertaken - CQUIN goal to halve the latter Early Warning System (EWS) in place since Dec 2011 and being monitored Referral rate and deterioration to referral time monthly audit All real cardiac arrests are reported as incidents via Datix and followed up by Resus Team and Root Cause established. New EWS CAS cards to trigger sick deteriorating patients in ED to ED Nurse in Charge and SpR/Consultant with clear SBAR handover to ward staff Deteriorating Patient Policy in place and on intranet since November 2011	Continued monitoring of EWS action plan and report to Quality committee until fully embedded. Audit in late 2011 shows significant reduction in ward cardiac arrest rate. Work ongoing in paediatrics embedding PEWS. Monthly audit of compliance and escalation started September 2012		Sep-12	4	1	4	**August 12 -** 90-100% compliance rate to NICE Guideline 50. Monthly CA / medical emergencies audit shows CA rate reduction to 1-2 a month (outside of ICU). Survival to DSC at 31% for adults and children (not neonates or trauma). New Quality Clinical Indicators targets set for Whittington Health to keep monitoring these and DNAR / TEPs for Quality Committee and Resuscitation Committee. SBAR tool introduced although only partially adopted. Controls and actions also updated.	→	Safety
June 2012	Trust wide	All clinical areas	Bronagh Scott, Director of Nursing and Patient Experience	N/A	Risk assessment following loss of funding.	Martin Grant, Lead Nurse for Safeguarding Adults	If the domestic violence post is not replaced (or an alternative sought) this could lead to high risk information not being shared, patients with domestic violence injuries not being appropriately supported and child protection risks not being identified.	4	2	8	Individual delegation occurs to ensure our statutory duties are complied with in relation to the MARAC (Multi-Agency Risk Assessment Conference) in both Islington and Haringey. A senior clinician from Whittington Health is attending the MARAC's. Champions in each clinical service to act as a link with statutory	A policy for domestic violence to be written and agreed to ensure a more robust system to be in place ensuring that information is shared with the lead agencies when required (timescale to be agreed). Policy written and going through process of sign off.		Sep-12				**August 12** - see actions	→	Safety
July 2012	Trust wide	All clinical areas	Celia Ingham Clark, Medical Director	N/A	Emergency National Support Team - Findings Acute Pathway	Divisional Directors and Heads of Nursing	If the recommendations of the National Support Team are not implemented: - patient safety may be compromised due to poor flows (resulting in increased outliers nad increased length of stay) - the CIP may not be achieved because extra beds will continue to be open at a higher cost - we may not be able to meet the 4 hour ED target as poor flow may lead to overcrowding in ED	4	2	8	Deliver all ECIST recommendations through close monitoring.	Deliver all ECIST recommendations through close monitoring. Monitoring arrangements - Acute Pathway Steering Group led by Medical Director and Program managed by a Senior Program Manager.		Sep-12				**August 2012** - acute pathway programme board in place and meeting fortnightly. Workstreams in place with clinical and managerial leads. Board Rounds introduced to improve patient flow through hospital.	→	All
July 2012	Trust wide	All clinical areas	Carol Gillen, Director of Operations	N/A	Escalated by division (SCD)	Carol Gillen, Director of Operations	If beds are not reconfigured there may be an increased number of outliers which have an adverse impact on patient care.	4	2	8	Monitoring by Trust Operational Board.	Focus to shift from bed reconfiguration to implementation of Emergency National Support Team findings, in order to improve flow, reduce length of stay and admissions which will lead to fewer beds.		Sep-12				**August 2012** - see actions	→	Safety