Trust Board Level Risks - April 2021

Sandwell and West Birmingham Hospitals NHS Trust

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	OWNER: Executive lead	Last Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating (LxS)	Review frequency	Status
1. 3110 29/12/2020	Corporate Operations	Informatics (C)	There is a risk that the technical infrastructure, Trust-wide is not robust nor subject to compliance against formal technical architecture and is therefore suboptimal. Combined with areas of legacy technology currently without a full plan to update or replace, there is an impact of loss of IT provision to run clinical and non clinical services safely and effectively.	5x4=20	1. IT infrastructure plan is documented and reports to CLE through the Digital Committee (but has slippage on delivery dates) 2. Infrastructure monitoring and alerting implemented following the installation of a system called PRTG. 3. Supplier warranted support contracts in place. 4. 3rd party contracts for provision of spares in place for equipment where a supplier warranted break/fix contract is not available.	Craig Bromage *Martin Sadler*	22/01/2021	3x4=12	1. Upgrade and replace out of date systems. We have spares and contracts for our older systems. (Target date: 31/03/2021) 2. With industry expertise advice fully document technical architecture (Target date: 01/07/2021) 3. Document a robust IT infrastructure plan with well defined scope, delivery milestones and measurable outcomes signed off via digital committee (Target date: 13/07/2021)	2x4=8	Quarterly	Live (With Actions)
2. 325 18/02/2021	Corporate Operations	Informatics (C)	There is a risk a breach of patient or staff confidentiality caused by cyber attack could result loss of data and/or serious disruption to the operational running of the Trust.	4x4=16	1. Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case 2. Annual Cyber Security Assessment 3. Monthly security reporting by Informatics Third Line Manager 4. Trust Business Continuity plans 5. CareCERT NHS wide and Trust specific alerting received from NHS Digital 6. Regular updates on suitable behaviour relating to scam emails and phishing.	Craig Bromage *Martin Sadler*	18/02/2021 Review overdue	4x4=16	1. Improve communications on intranet about responses to suspicious emails. (Target date: 01/06/2021) 2. Conduct a review of staff training (Target date: 01/06/2021) 3. Hold cyber security business continuity rehearsal. 1. Agree scope with Emergency Planning Lead 2. Plan and hold rehearsal 3. Review lessons learned (Target date: 01/06/2021) 4. Upgrade servers from version 2003. (Target date: 01/06/2021)	2x3=6	Monthly	Live (With Actions)
3. 214 23/06/2020	Corporate Operations	Waiting List Management (S)	The lack of assurance of the 18 week data quality process, has an impact on patient treatment plans which results in poor patient outcomes/experienc and financial implications for the Trust as it results in 52 weeks breaches. There is a risk delay in treatment for individual patients due to the lack of assurance of the 18 wee data quality process which will result in poor patie outcome and financial implications for the trust as result of 52 week breaches	4x3=12	1. SOP in place 2. Improvement plan in place for elective access with training being progressed. 3. training completed with competency assessment for operational teams involved in RTT pathway management 4. ongoing audit and RCA process to learn and provide assurance 5. Initial & ongoing clinical prioritisation of all patients on the Trust's Inpatient waiting list inline with national and local prioritisation. (ie P2-4) & (P5 & P6)	Mark Whiteho *Liam Kennedy*	17/03/2021	2x3=6	1. Matrix dashboard to monitor compliance against the SOP (Target date: 31/08/2021)	1x3=3	Six-Monthly	Live (Monitor)
4. 3689 17/03/2021	Finance	Financial Management (S)	SBAF 10 - NHS Contracting And Payment Mechanism	4x4=16	1. ICP Boards held monthly, Trust attendance 2. STP Board attendance, relationship between ICS and ICP 3. STP DoFs group - finance framework development. 4. Membership of National HFMA Payment Systems & Specialised Commissioning Committee 5. Finance sub groups established for both places 6. Fortnightly catch up with Trust CFO and CCG Finance lead 7. Chair of ICP Boards requirements are clear 8. Leadership alignment work underway 9. Draft plans for both places presented to Boards 10. SWB position on acute care collaboration has been clear and consistent, case for change reflects that 11. CFO attends STP reset programme board	Dinah Mclanna *Dinah Mclannahan*	17/03/2021	3x4=12	1. Capacity in CCG to work on this given CCG merger work (Target date: 30/06/2021) 2. Agree multi-year agreement / envelope from 21/22 onwards, aligned to 20/21 system allocation LTFM costs and place plans - tariff for 21/22 likely to be one year only (Target date: 30/06/2021) 3. Determine ICS wide savings versus ICP wide efficiency opportunities (Target date: 30/04/2021)	2x4=8	Bi-Monthly	Live (With Actions)
5. 2642 18/03/2021	Medical Director Office	Medical Director's Office (C)	There is a risk that results are not being acknowledged by individual clinicians due to failur to follow process leading to delayed or omitted treatment.	3x5=15	1. Post Unity some radiology reports need acknowledgement in CSS and will be monitored. Completed. 2. New report in Unity for compliance of pathology and radiology endorsement, by location, by patient, by person 3. Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 4. SOP - Results from Pathology by Telephone (attached) for clinically significantly abnormal results 5. Appropriate training is available for correct process to follow when ordering investigations to ensure the results come back as solicited and therefore available to endorse in the message centre and patient record. 6. Monthly review of position regarding results endorsed/ unendorsed which is communicated to groups. 7. Regular monthly review of unsolicited pathology requests.	David Carruthe *David Carruthers*	07/02/2021 Review overdue	3x5=15	1. To review and update Management of Clinical Diagnostic Tests (Target date: 30/06/2021) 2. Update existing eRA policy to reflect practice in Unity (Target date: 30/06/2021) 3. Review / update of training material, mode and frequency of delivery. (Target date: 31/05/2021) 4. Review / update Comms for key messages relating to results acknowledgement. (Target date: 30/04/2021) 5. Establish process for correct consultant allocation of patients. (Target date: 31/05/2021)	1x5=5	Monthly	Live (With Actions)

Where EVERYONE Matters

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6. 3693 07/02/2021	Medical Director Office	Medical Director's Office (S)	SBAF 14 - There is a risk that the Trust is unable to reduce amenable mortality to the timescale set ou in our plans because we do not identify interventions of sufficient heft to alter outcomes.	5x3=15	1. Management structure substantially in place to support LfD programme. -Deputy Medical Director in post -1 WTE Medical Examiners in post -Medical Examiner officer in post. -Mortality Manager appointed. -Admin support agreed. 2. Learning from deaths programme in place with sub-streams set out below. 3. 1. Mortality reduction plan in Quality Plan relating to Sepsis, VTE, Acute MI, Stroke, #NOF, High risk abdominal surgery and Peri-natal mortality. QI projects identified. 4. 2.Data analysis programme focussing on alerts arising from clinical areas and/or conditions. Coding processes improved. 5. 3.External mortality alerts from CQC or CCGs. 6. 4. Medical examiners are substantially in place. MEs and judgmental reviewers will provide 3 monthly analysis of amenable mortality.	David Carruthe *David Carruthers*	23/08/2020	4x4=16	1. Further improvements in coding underway focusing on palliative care data, weekend admissions and site specific. (Target date: 01/06/2021) 2. to maintain ME review of cases (tier 1) and identify cases for SJR review including training for additional SJR reviewers. (Target date: 01/06/2021) 3. COVID mortality closely reviewed and SJRs undertaken where required. (Target date: 30/04/2021) 4. Implement mechanism to have a reduction in total number of consultant episodes. (Target date: 30/06/2021)	3x4=12	Annually	Live (With Actions)
7. 1762 31/03/2021	Surgery	BMEC Outpatients - Eye Centre	There is a risk that lack of capacity to review patients within the ophthalmic clinics caused by: a) lack of diagnostic area / personnel to support reviews and increased virtual reviews b) inadequate clinical rooms c) reduced clinic staff (currently resolved with repatriation of staff 31.03.21) results in patients being reviewed after the requested timeframe (utilising the 25% RCOphth slippage guidelines) leading to poorer clinical outcomes and adverse impact on financial / busine outcomes.	5x3=15	1. daily monitoring of situation occurs through Group PTL structures. 2. Additional PRW clinical sessions undertaken, authorisation process with exec team followed 3. Introduction of daily 'tail gunning' report to EAT to support booking of vacant slots to increase capacity effectively. 4. Use of failsafe reports by Service Managers and PAMs to identify high risk pathways	Hilary Lemboye *Liam Kennedy*	15/03/2021	5x3=15	1. improve room capacity within BMEC OPD through the creation of new rooms - capital plan item (Target date: 30/09/2021) 2. Resolution of RAG rating flag within all consultant led work. Currently only a proportion of clinics can see this. : Note, Solution is developed, awaiting testing data from Informatics a) Solution to be tested once information is provided b) Solution to be implemented (Target date: 30/04/2021) 3. Insufficient test capacity which extends waits for appointments for patients needing tests: Business Case for a diagnostic hub and implementation of same if approved (Target date: 30/06/2021) 4. some erroneous entries in the backlog that need to be routinely cleared - a) validation trajectory to be re-set & delivery monitored / managed weekly by Service Managers weekly b) look for auto solutions to the problem and implement these (Target date: 30/04/2021) 5. Parent / Child Issues create additional burdens on the backlog size: meeting to develop a solution to this put in place the solution (Target date: 30/04/2021)	2x3=6	Quarterly	Live (With Actions)
8. 2784 10/02/2021	System Transformation	MMUH Strategic Project	The Trust may not deliver the project within the agreed financial envelope. As a consequence, the Trust may need to divert funding from other projects or work-streams to pay for compensation events (for changes, delays etc) that arise during construction (in line with the NEC4 contract) phase of Midland Met if the total value of compensation events exceeds the contingency budget that is within the Midland Met project budget/funding. This could impact on the overall delivery of the necessary capital programme.	5x5=25	1. Estates Strategy / Capital programme under constant review to maintain effective use of scarce capital 2. Plans for change are reviewed and mitigated to reduce cost 3. Agreed BB project scope	Simon Sheppard *Toby Lewis*	17/03/2021	4x5=20	1. Weekly review of raised compensation events to agree response, request for additional information/quotes & compensation events to be taken to Estates MPA for approval (Target date: 31/12/2021) 2. Manage early warning and compensation event process in line with NEC 4 contract (Target date: 31/03/2022) 3. Conclude design validation of MEP (Target date: 31/03/2021) 4. Regular update of cashflow and cost forecasting for project (Target date: 31/03/2022) 5. ensure valid documentation of control plans over 5 years (Target date: 31/03/2021) 6. work with NHSI/e on covid reimbursement costs (Austin Bell) (Target date: 31/12/2021)	2x4=8	Quarterly	Live (With Actions)
9. 666 18/02/2021	Women & Child Health	Paediatrics (S)	There is a risk that children and young people are admitted to an acute paediatric ward when requiring a specialist Tier 4 mental health support bed, which will result in sub-optimal therapeutic clinical care delivery to that child or young person. This is due to a lack of Tier 4 CAMHs beds nationally	4x4=16	1. Mental health agency nursing staff utilised to provide care 1:1 2. All admissions monitored for internal and external monitoring purposes. 3. Awareness training for Trust staff to support management of patients is in place 4. Children are managed in a paediatric environment. 5. Close liaison with specialist Mental Health CAMHs staff to support management whilst inpatient on ward.	Brenda Taylor *Liam Kennedy*	15/02/2021	4x4=16	1. Audit number of CYP admissions with LOS on acute ward requiring specialist inpatient CAMHs support and escalate to MH commissioning team (Target date: 30/04/2021)	4x4=16	Quarterly	Live (With Actions)