Risk 1 2136 Risk to delivery of services resulting from multiple estates related challenges including non compliance & resilience **Risk Owner - Director of Strategy & Infrastructure (Estates & Facilities)**								**Risk Target: 16**
Relating to Objectives – 1. Provide safe patient care 3. Improve the patient experience.							**Links to Corporate Risks – Sustainability of estate: CQC outcome – 10**	
			Residual Score					
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1** **I x L**	**Qtr2** **I x L**	**Qtr3** **I x L**	**Qtr4** **I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: ▪ Non compliance with CQC Outcome 10 ▪ Interruption to delivery of services ▪ Patient, staff, visitor harm ▪ Reputational damage ▪ Financial loss ▪ HSE prosecution	Policies/procedures available to all staff via the Trust Internet. Responsible Officers designated. Estates governance framework in place, supported by accountability structure. Sustainable Management Plan approved by Board, September 2011. Actions/outcomes of health & safety and security assessments are tracked through to completion by managers and reported through to sub-committee and / or risk management group. CQC Action Plan in place and progress made against actions Mandatory Staff skills/training programmes ongoing to meet training needs assessment. Risk Assessment training carried out by Health and Safety Manager to all estates senior management. Site health & safety and security assessments.	(-) Skills and competencies gaps being addressed by recruitment drive. (+) Head of Estates recently appointed (+) second restructure and review of JD/ Roles for estates staff (2011 & 2012\0 to address accountability and leadership. (+/-) Capacity and Resilience Report of 2008 not fully implemented but aware and working on gaps. (-) Compliance audits revealed areas of non compliance, including in Asbestos Management. (-) Internal review of Asbestos Management confirmed major non compliance. (+) close working with H&S officer and estates responsible officer for asbestos – on process and guidance issues. (+) temporary post to co-ordinate action and identify back log risks and priority actions.	**5 x 5** **25**				**CGAPS:** 1.Emergency Procedures Manual not yet completed. 2. Estates Management Plan 2012/13 not yet completed. 3. Risk Management Process not fully implemented. 4. Funding of compliance and resilience works not fully agreed.	Estates Compliance Report to Board March 2012: **Actions:** Implement Estates Risk Report action plans within funds available. Finalise estates staffing structure. 6 Facet Survey out to tender. Asbestos removal under way to all sites within available funds. Water management risk assessments and undertake alterations. Electrical LV survey under way. Medical Gases Authorising Engineer out to tender. Review of Backlog Maintenance Priorities following compliance reports.

Risk 2 2766 – Risk of Exceeding monthly trajectory for HCAI Risk Owner - Director of Patient Safety, the Medical Director								**Risk Target 5**
Relating to Objectives – 1. Provide safe patient care 3. Improve the patient experience							**Links to Corporate Risks –**	
Risk 3 2767 Risk of exceeding HCAI trajectory by year end. Risk Owner - Director of Patient Safety, the Medical Director								**Risk Target 5**
Relating to Objectives – 1. Provide safe patient care 3. Improve the patient experience							**Links to Corporate Risks – CQC Outcome:**	
			Residual Score					
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
2766 Consequence: will result in adverse Governance Performance Rating with the SHA/PCT **2767 Consequence: Planned trajectory is 2 MRSA, C.Diff trajectory of 33**	1. HCAI Policy informs controls in place. 2. MRSA/CDiff Review meeting bi-weekly and Infection Control Link Nurses in place. 4. Infection Control Committee review monthly 5. RCA provides in-depth analysis to inform further clinical management actions. 6. Frequent infection control education/training for staff. 7. High impact intervention audits and invasive devices audits. 8. Extended ward rounds inc microbiologists. 9. Mystery Shopper Audits involving Directors and Medical Director walkabouts on a monthly basis. 11. Review by Drugs & Therapeutics Committee of antibiotic audits monthly.	(+) 1 MRSA against trajectory of 4. (+) Good practice in place reflected in well within trajector (17 C. Difficiles out of trajectory of 33). for 2011/12. (+) Hand hygiene audits (weekly) February 99%; (+) Commode Audits evidence +80%; (-) performance fluctuates in high activity (+) PEAT scores consistently good (+) HCAI monitoring and surveillance reports. And as above. Environmental audits (monthly) (-) Antibiotic audit Feb reported overall increase in Piperacillin, tazobactam, co-amoxiclave and orgal cefuroxime.	**2766 4x4 16** **2767 4x3 12**				**CGAP** access to isolation ward continues to be affected by bed pressures. **CGAP** Deep cleaning programme continues to be affected by high levels of activity making it difficult to access wards on a consistent basis.	**2766** The impact of a breach in month has informed the rating at 16, although the Trust was well within trajectory last year and remains well within annual trajectory ongoing vigilance is required.

Risk 4 2755 – Risk to status of Trust as provider of postgraduate medical training from concerns raised following visit by East of England Deanery on 10 October 2011 Risk Owner - Director of Patient Safety, the Medical Director							**Risk Target: 5**	
Relating to Objectives – 1. Provide safe patient care; 7. Attract, retain and motivate an appropriately trained workforce.			**Links to Corporate Risks – Relating to CQC outcomes inc 1, 4 and 14**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Inability to deliver service if approval withdrawn to train postgraduate doctors.	1. Junior Doctor Task Force established led by Medical Director with support of Director of Delivery and key actions identified.	(+) CQC inspection found Trust compliant with Outcome 9 (Medicines) and Outcome 16 (Monitoring Care). ***(+) 260412: Deanery Re-visit informal feedback indicates sufficient middle grade support in place for junior doctors in midnight to 8 am shift. (+) An internal audit has identified that there were 340 applications for study leave in the financial year 10/11 of which 9 (2.6%) were refused.These were all refused within our current guidelines (+) Audit of Grand Round topics covered in calendar year. (+) Informal feedback from Deanery re-visit on 26 April demonstrates 1 condition remains re: patient tracking in ACMD. Others found to be addressed.***	**5x2 10**				**CGAP**: Posts provided via London Deanery and junior doctors attracted to London Teaching Hospital. **CGAP**: Inability to influence number of training posts supported.	**Action Plan re patient tracking in AMCD has been sent to the Deanery and risk placed on AMCD risk register effective w/b 300412.**

Risk 5 2776 – Risk to delivery of safe care and safe working practices from the current model of care in maternity theatres and delivery suite. **Risk Owner - Director of Nursing**							**Risk Target 5**	
Relating to Objectives – 1. Provide safe patient care; 2. Improve outcomes & quality			**Links to Corporate Risks – Relating to CQC outcomes inc 1 and 4**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**5x1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **This presents a risk to compliance (CQC and safe standards of surgery guidelines, compliance with NE guidance).**	**Current Controls**: Maternity Theatres Review Project (executive led) overseeing implementation of improvement action plan. Project Tracker monitored by Maternity Theatre Project Manager and reporting to MTRP. Phase one: Developed two distinct pathways for women: elective list is independently staffed and overall staffing ratios have been increased. Key policies updated and theatre related policies to be aligned to maternity theatre settings.	(+) No further reported Never Events since September 2011. Audit findings following WHO checklist.	**5x2 10**				**CGAP:** Phase 3 not yet completed. (Amalgamation of maternity and gynae theatres within Trust theatre management led by Surgical Division). Business Case to be presented to Divisional Boards and DISE (May).	**Phase 1 of 3** phased plan nearing completion (o/s: Theatreman data capture system being adapted for Maternity setting). Staffing model, case approved. Business Case for capital build (additional bed space, modification theatre suite) on hold pending agreement about funding. Close monitoring via Maternity Theatres Review Project, chaired by the Director of Nursing.

Risk 6 1272 – Risks from non compliance with HBN's/ HTMs Risk Owner - Director of Strategy & Infrastructure								**Risk Target 6**
Relating to Objectives –							**Links to Corporate Risks – Relating to CQC outcome – 8 and 11**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Risk of contamination and risks of not meeting the conditions of CQC registration (Outcomes: 8 and 11)**	1. Decontamination Programme Board 2. Staff training 3. Approved person in place 4. Action plan 5. Revised TSSU delivery strategy agreed with Trust Board 6. Board agreed IHSS out-sourcing strategy. 7. WGH Endoscopy: P21+ Contractor appointed. Solution identified and budget being reviewed. Forecast for completion is late autumn 2012. 8. Manual inspection of theatre instruments prior to use is part of normal practice.	(+) Trust has committed capital spend to WGH Endoscopy decontamination for early 12/13. (-) Risk of existing equipment failing was accepted by Programme Board at the time of the decision to progress HHGH ahead of WGH endoscopy. (+) HHH Endoscopy unit operational (+) Decontamination contract signed with independent supplier	**3x3 9**				A – Contract signed and further work on operational solutions required and testing of flow patterns underway. A – Review of final options went to Finance Committee 10th May 2012	HHGH Endoscopy Scheme "gone live". Minor issues with temperature control in unit when under full load being addressed. The Decontamination Compliance Programme Board has agreed the risks associated with slipping were minimal with the controls in place. This has been discussed and agreed with the Chief Executive and Medical Director. ***The contract with IHSS/ NW London was signed on 15 May 2012.*** **(Board received a report at the March meeting)**.

Risk 7 2719 Risks relating to increased levels of demand for emergency services: increased attendances at A and E and increased volumes of medical admissions. Risk Owner - Chief Operating Officer							**Risk Target: 4 x 2 = 8**	
Relating to Objectives – All			**Links to Corporate Risks – Relating to CQC outcome – 4**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Risk of failing to deliver key quality and operating standards within existing budget. Impact on capacity throughout the pathway (including key targets) and collateral risk of reducing patient experience	1. Emergency Task Force (executive led) continues to meet weekly to streamline decision making and reinforce agreed changes. 2. Daily monitoring of patient flow. 3. Escalation (Surge) Plan in place. 4. Clear position in relation to beds required per day established (the Bed Model).	(+) Trend is showing a marked improvement in performance across a range of operational indicators in Q4 as detailed in the Performance Report to March suggesting the risk is controlled. (-) Elective surgery cases continue to be cancelled or care transferred out. High volumes reported in Q4 to date, although lower than Q4 2011 to date but creates pressure and poor patient experience. (-) Failure to deliver18 weeks admitted Q4 at 89.6%. (+) year to date position against standards remain less fragile than 2011.	**4x5 20**				**CGAPs** ***1. Ongoing risks relating to junior medical staffing partly, mitigated as per Deanery update.*** ***2. Still too much variation in practice in managing patients.***	*1. System navigator in post.* *2. Middle grade medical recruitment has resulted in good quality long term locums in place.* *3. 2 Consultants appointed.* *4. ECIST action plan fully implemented.* *5. Shared analysis with PCT and tacit support to our proposals for capacity expansion. Proposals will be taken to the Board in May.PCT recognises changed patient flows, which is reflected in the 12/13 contract value.*

Risk 8 2143 Inability to discharge patients when acute medical care no longer required Risk Owner - Chief Operating Officer							**Risk Target:** 4 x 2 = 8
Relating to Objectives – 2. Improve the Patient Experience; 6. Work in active partnership.			**Links to Corporate Risks – Relating to CQC outcome –**				
			Residual Score				**Qtr1 I x L**
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (+) – Negative (-)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: impacts upon the Trust's ability to deliver it's elective workload and its ability to achieve A&E targets. It also risks a detrimental impact on patients. The inappropriate use of acute beds for patients no longer requiring acute care compromises access of beds for those in need, whether via acute admission or elective requirements.	1. Daily monitoring of patient flow. 2. Daily meetings with Hertfordshire Community Health Services and Adult Social Care to improve planning of supported discharges. 3. Social Work Team now based in acute hospital in the Bed Management Office. 4.COO chairs Stakeholder Discharge Planning Group.	(+) Performance reports to Board. (+) Weekly CEO reports. (+) Breach reporting and detailed review of causes. (+) Within performance tolerance for delayed transfers of care. (+) More patients being re-directed to appropriate care. (+) Performance against core access targets within tolerance for Q1 but substantial issues remain to be addressed.	**4x4 16**				**CGAPS:** 1. Volume of activity continues to spike on a daily basis and acute admissions continue to rise year on year as per analysis presented to Board in March. 2. Availability of social services staff to maintain timely assessment of patients admitted to the AAU 3. Issues of funding formula for Adult Care Services as a result of local authority cost reduction targets have compromised system efficiency.	Emergency admissions continue to rise and there continues to be delay to discharging patients requiring community based care. Navigator role should support the improvements required.

Risk 9 2739 There is a risk to delivery of high quality maternity services, including failing to achieve key requirements in relation to Care Quality Commission outcomes for maternity services. Risk Owner - Director of Delivery							**Risk Target: 4 x 1 = 4**	
Relating to Objectives –							**Links to Corporate Risks – Relating to CQC outcome –**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Risk that could threaten the organisation's objectives to: Provide safe patient care, improve outcomes and quality of care, be financially sound and attract and retain suitably qualified staff. Related risks include 1998, 2675, 2659, 1379 (Staffing and Leadership) 1379, 2659 (capacity matching increased level of activity) and 1998 (patient safety).**	**Staffing:** Recruitment and Retention Strategy. Action Plan agreed to move maternity establishment from 1:34 to 1:30 by Sept 2012, agreed by PCT and SHA. **Patient Safety**: Divisional Risk Manager reinforcing incident reporting and learning. Project Manager in place for Maternity Theatre Review action plan implementation. **Clinical Effectiveness**: Quality Assurance Midwife fully engaging division in monitoring and sharing best practice. **Maternity and Neonate Capacity Group** - objectives achieved. Work complete.	(+) Achieving quick turnaround for potential midwifery candidates (-)CD Obstetrics post currently vacant although interim arrangements in place. (-)Delivery Suite lead post vacant. (+) 3 newly appointed Midwifery Managers/Matrons took up post in February (+) Positive feedback from new recruits on their experience of the maternity unit. (+) monitoring activity following cap suggests no adverse impact. ***(+) C Section rates being closely monitored but since January rates have reduced to within tolerance***. (-)Number of unapproved incidents continues to be high. Approval rates for newly reported incidents achieved within Trust guidance. (-) Ratio of supervisors to midwives remains unacceptably low. SHA outlier. (-) Low levels of completion of required clinical audits.	**4x3 12**				**CGAP** Continued Over-reliance on agency staffing. **CGAP** Backlog of incidents awaiting uploading to NRLS (see improvement assurance).	1. Supervisors of Midwives team being supported by 1 external supervisor. 3 Supervisors recently appointed. 2. Build completed January 2012. 3.. Midwifery vacancy rate: 16.4% - a reduction. Ratio 1:32 currently. 3. Theatre improvement implementation is making good progress but reconfiguration of theatres on hold pending funding decision. 4. CNST assessment planning started, informal review suggested on plan for Level 2. However resource implications need to be considered.

Risk 10 2287 – Failure to deliver 10 days cash balance at year end and achieve an opening liquidity ratio for 13/14 of 3: **Risk Owner - Director of Finance**							**Risk Target: 5 x 1 = 5**	
Relating to Objectives – 1. Be financially sound.							**Links to Corporate Risks – Achieve FT**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L 5 x 2**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Foundation Trust application may be deferred. Trust may have insufficient cash to pay suppliers and staff.	Close management of cash levels (managing receipts and payments to maximise cash position). Active cash management and reports to Finance Committee and Board. Liaison with PCT about profile of contract payments to manage cash especially if FT authorisation and loan re-scheduling are delayed until after March 2013. Controls as detailed in risk 2286.	The yearend cash balance achieved for 11/12 was £9.8m but this includes £7m funding for the Croxley Rail Link road to be passed to WBC/Campus in 12/13. The liquidity ratio for 12/13 will now be 3, due to the extra £7m. There is a rolling cash flow plan.	**10**				**CGAP:** Decision awaited from DH.	Continue work to delivery GB (CIP) savings and achieve planned surplus. See also 2286.

Risk 11 2146 – Risk that the Trust fails to be put forward to the DH Technical Committee in August 2012 **Risk Owner - Director of Communications**							**Risk Target: 4 x 1 = 5**
Relating to Objectives – All			**Links to Corporate Risks –**				
			Residual Score				**Qtr1 I x L**
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Failure to achieve FT status.**	1. Foundation Trust Project Board 2. Executive Lead for Foundation Trust application. 3. Provider Management Regime (PMR) meeting on a monthly basis with the SHA. 4. Tripartite Agreement signed September 2011 DH, WHHT and SHA.	1. Application put forward to DH Technical Committee by SHA on 1 April 2012. (P) 2. Application received Category C – further work to be undertaken to address issues in LTFM. (N)	**4 x 3 = 12**				1. Further work on CIP. 2. Further modelling required in LTFM.	1. Development Programme out to tender. 2. Recommendations in HDD actioned. 3. Board Governance Memorandum being completed. BGAF project underway. 4. DH requirements reviewed by Finance Committee on 10 May and issues for Board Review Part 2 on 31 May 2012.

Risk 12 – 2659 Significant financial risk associated with Maternity Staffing budget to achieve and maintain required staffing ratios. **Risk Owner - Chief Operating Officer**								**Risk Target: 4**
Relating to Objectives –							**Links to Corporate Risks – Relating to CQC outcome**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Failure to deliver services within financial resource.**	1. The Maternity Staffing Strategy (revised November 2011). 2. Maternity Escalation Policy 3. Action plan to reduce the midwifery vacancy rate to 1:30 by December 2012. 4. Action Plan to reduce the sickness rate to a minimum of the Trust's average 4%;	(+) Achieving quick turnaround for potential midwifery candidates (+) 3 newly appointed Midwifery Managers/Matrons took up post in February	**4x2 = 8**				**CGAP** ongoing challenges in recruiting to local vacancies because of a national shortage of midwives.	1. Maternity Escalation Policy continues to work well and an effective control. 2. Sickness rates have responded to the action plan in place resulting in positive progress.

Risk 13 2722 – Risk of PCT intention to reduce hospital based demand faster than reflected in IBP base case. Risk Owner - Director for Partnerships								**Risk Target: 5**
Relating to Objectives –			**Links to Corporate Risks –**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: will result in a reduction in income without related reduction in capacity.	1. PCT contract monitoring. 2. Weekly performance monitoring. 3. Monthly PMO meetings with Finance and Divisions. 4. Access meetings.	(+) Referrals from all sources stable - currently the case. ***(+) Slight reduction in GP referrals***. (-) IA report on Theatre Utilisation identifies efficiencies to be gained within existing demand base. (-) Outpatient review by Meridian identified inefficiencies in outpatient clinic utilisation.	**5x2 10**				**CGAP** Continue to have limited control over referral patterns. Potential impact from changes at East & North Herts Trust (relocation of service from Welwyn to Lister).	1. Mitigation Action Plan will be initiated if PCT commissioning intentions towards reduced demand are realised. 2. Review of clinic and theatre capacity has resulted in consolidation of clinics to deliver greater efficiency. 3. Developed capability to plan up to 8 weeks in advance the number of clinics required to meet the number of referrals. This will also mitigate the risk. 4.More flexibility in theatre use will facilitate responsiveness to potential market led demand changes.

Risk 14 1512 – Inability to organise and treat patients within the 18 week referral to treatment target because of a lack of capacity. Risk Owner - Chief Operating Officer and Director for Partnerships: Responsible Manager: Kirsty Green								**Risk Target: 5**
Relating to Objectives –			**Links to Corporate Risks –**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**5x2 10**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: This will affect performance and governance ratings and impact on patient experience.	1. Weekly performance reviews 2. Information tracking for outliers/concerns. 3. Data validation to remove errors. 4. Breach reporting and detailed review of causes.	(+) Performance Reports (+) Proactive approach for identifying and averting potential breaches has now been embedded. (-) Backlog of patients static but not decreasing. (-) Cath lab activity continues to be lost to accommodate surge. Watford General Hospital elective activity lost to accommodate surge in demand. (+) Weekly reports on situation and performance to PCT	**5x2 10**				**CGAP**: referrals dropped by 2% against previous year but still above PCT plan for 12/13. PCT demand management plan not realising the required level of reduced demand. **AGAP** service design has not yet delivered shift in activity, i.e. through admission prevention.	**1. Pursuing further short term capacity to manage demand and avert use of cath lab.** 2. Work is ongoing to optimise elective capacity at SACH. 3. Weekly review of operating list efficiency in place, similarly with outpatient utilisation. 4. Surgical division confident of process for 18 week tracking. 5. Arrangements to outsource where more than 2 cancellations have occurred or potential 26 weeks breach.

Risk 15 – 2286 Risk of failing to deliver a surplus and maintaining an FRR of 3 through not achieving savings targets (including delivery of 'Getting Better programme) and budget overspend. Risk Owner - Director of Finance							**Risk Target: 5**	
Relating to Objectives –			**Links to Corporate Risks –**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 5x4 20**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Will compromise the Trust's ability to meet the financial assurances required to achieve authorisation as a Foundation Trust.	1. Monthly financial reporting. 2. Quarterly performance reviews. 3. Monthly divisional performance meetings to review spending and income against budget and progress in delivering savings. 4. Getting Better (CIP) governance structure. 5. Vacancy Control Panel meets weekly to control recruitment. 6. Regular meetings with PCT to review contract performance.	(-) GB performance behind schedule in April. (-) Headcount not reducing (-) emergency pressures may increase level of savings required. (+) Review of WHHT arrangements for securing financial resilience by external auditor in May 2012 identified areas of strength and recommended some improvements. (+) New leadership and re-launched savings approach in place for 12/13.	**5x3 15**				CGaps • Funding for additional emergency capacity not yet identified. • Delay in gateway forms being signed off. • Full savings plan for 12/13 not yet finalised.	1. Strengthen Executive Director in-put to Getting Better programme. 2. Bids to PCT for Transformation Funds to be completed. 3. Further actions required to finalise savings plan.

Risk 16 1465– Inadequate data quality: Risk Owner Director for Partnerships								**Risk Target: 5**
Relating to Objectives –			**Links to Corporate Risks –**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 4x2 8**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: compromises Trust's ability to recover income and plan and monitor performance.	Weekly and monthly monitoring of data timelines and completeness/IM&T strategy/Data Quality Group review against a number of measures to undertake actions. Monthly assessment of lost income attributable to inaccurate coding. Missing data items are identified on a daily basis through a WHICH Doctor report and corrected by the Data Quality team. SUS data comparisons show the Trust is in the upper decile for completion of minimum dataset information. There still remains a risk, particularly in Maternity, about poor data collection and late recording of activity and work is ongoing with the Data Quality team to address this with the clerical staff and community midwives.	(+) Positive reporting at Weekly Performance Meetings/ Monthly Director of Finance Report to the Trust Board/IM&T strategy/Internal Perf reports. (-) Prior approval audit (IA) dated 310811 indicates Amber Red.	**4x2 8**					1. Regular Data Quality Checks. 2. Identify actions required to address deficiencies identified in the Data Assurance Framework Audit. 3. Programme of coding audits is now established and undertaken by Coding Auditor. Individual coders' performance reviewed weekly by Coding Manager. Specialty reviews undertaken on a monthly basis on a rolling programme, with the clinical lead. 4. Amber/Red internal audit issues addressed - inaccurate coding reducing and prior approval reviewed on a monthly basis as part of PCT validation and now regarded as minimal.

Risk 17 2596– Failure to influence and work with partners to deliver affordable patient care in a complex system. **Risk Owner - Director for Partnerships**							**Risk Target: 4**
Relating to Objectives –			**Links to Corporate Risks –**				
			Residual Score				**Qtr1 I x L**
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1** **4x2** **8**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Potential loss of contracts.**	1.QIPP Partnership Board. 2. Clinical Partnership Board 3. System wide Chief Executive meeting held monthly. 4. PCT quality meeting.	(+) PCT joint work on service re-design, including Ophthalmology, oral surgery and NSK. (+) reduction in outpatient referrals continue to reduce requirement for first outpatient attendances.	**4x2** **8**				**CGAP** Lack of support from GPs for QIPP process. Failure to recognise increasing demand for services. Activity shifts from East and North Herts to WHHT now being recognised. **CGAP** Patients that still come through the system are likely to be more complex and require ongoing complex treatment - this will challenge our ability to reduce capacity in line with PCT expectations.	1. A GP representing the Herts Valley Clinical Commissioning Group now attends the monthly SLA and Quality meetings between the Trust and the PCT. 2. The Clinical Partnership Board is fully established. 3. A series of meetings between GPs and individual specialties has commenced.

Risk 18 2598– Failing to recruit, retain and motivate appropriately trained workforce : Owner Director of Workforce							**Risk Target: 8**	
Relating to Objectives –			**Links to Corporate Risks –**					
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 4x3 12**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Will result in poor quality services and inefficient delivery.** **Risk Owner - Director of Workforce**	1. Organisational Development Strategy 2. Staff Survey Action Plan. 3. Mandatory Training and Appraisal plans. 4. Nursing and Midwifery Strategy; 5. Health and Wellbeing at Work Framework; 6. Equality Delivery System; 7. Deanery Action Plan in relation to Junior Doctors.	(-) Use of agency staff including medical locums remains high (+) Improvements recorded in appraisals and participation in mandatory training. (+) Improvements evident in staff survey (+) Lower levels of sickness reported.	**4x3 12**				**CGAP** Proximity to London and other FTs creates competition for qualified candidates. **CGAP** inflexibility of Agenda for Change pay rates. **CGAP** Monitoring system not currently ensuring CRB status up to date. **CGAP** national shortages of midwives, ODPs, Middle Grade A & E doctors.	1. Developing a People Strategy that better reflects current workforce challenges. (May 2012) 2. Refresh staff survey action plan (May 2012). 3. Refresh appraisal and training plans (June 2012). 4. Progressing review of consultants' job planning (April 2012). 5. NHSP contract in place.

Risk 19 – 2145 Inadequate resilience in core IT systems, and inadequate fallback and disaster recovery arrangements **Risk Owner - Director of Finance**								**Risk Target: 4**
Relating to Objectives –			**Links to Corporate Risks –**					
Relating to CQC outcome –								
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 4x2 8**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: **Will threaten the functioning of hospital information systems resulting in (I) threats to service delivery (ii) ability to provide assurance through performance & activity monitoring and income recovery.**	**Resilience** 1. Specialist fire and security arrangements for infrastructure/systems. 2. Systems resilience between sites and within site networks. 3. Data back up arrangements. 4. Fall back/disaster recovery systems in place. 5. Disaster recovery policies & procedures in place and staff trained **Operational System needs** 1. Stakeholder group established between IT and the Clinical /Business leads for Maternity, AAU and A&E. 2.Specialist system training available 3. AAU help desk calls are now prioritised for severity .	(+) Regular disaster recovery table top testing undertaken by systems owners and users. Owner –Head of Clinical and Business Applications . (-) IT Disaster Recovery Audit Owners –IT /Internal and external Audit (+)Information Governance compliance Owner- Associate Director of Clinical Informatics	**4x4 16**				**CGAPS:** 1. Limited Monday to Friday helpdesk and out of hours cover for some systems. 2. Inter-site resilience offers only limited capacity. 3. Poor on-site resilience at SACH. 4. Disaster Recovery contract not in place. 5.Aging PAS and Clinical systems fails to meet service needs. 6.Lack of real time data impacts patient care /experience. 7.Poor network /infrastructure and Insufficient end user devices impacts on Clinical Productivity.	1. IT Strategy to address IT risks and provide future proofing to the Hospital to be presented at May Trust Board for approval. 2.Single sign-on and improvements to users access to be implement 3.Regular IT presence in AAU to support key users 4.Changes to AAU Clinical office areas to be implemented and additional PCs to be deployed. 5. Work started to achieve quick operational improvements. 6. OBC for infrastructure being developed. 7. Board recognition of need to invest.

Risk 20 2721 – Failure to follow data confidentiality procedures and failures in systems security will put the Trust at risk of breaching codes of confidentiality in respect of personal identifiable information. **Risk Owner - Director of Finance**							**Risk Target:** 4
Relating to Objectives –			**Links to Corporate Risks –**				
			Residual Score				**Qtr1 I x L**
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1** **4x3** **12**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Failure to meet national standards for Information Governance will result in risk to patient confidentiality, data loss and Trust reputation. May result in financial penalty being imposed by Information Commissioner's office.	1. Access and technical controls in respect of operation and use of key information systems. 2. Implementation of data encryption systems. 3. Information Governance Policies 4. Annual mandatory Training and awareness programme. 5. Information Governance Structure. 6. Data Encryption Implementation Project 7. Port Control has been activated.	(-) Annual data mapping exercise to control and identify PID to recipients outside the Trust - information transmitted includes clinical letters, pathology reports, theatre lists. Owner- Information Governance Manager Information Governance tool lkit compliance Owner-Information Governance Manager	**4x3** **12**				**CGAPS:** 1. Still possible for data to be saved on unencrypted CD media. 2. Training targets currently below target. 3. Emails containing PID are being monitored but not being blocked .Users are warned that they may have breached DPA. 4.Dispite managers being notified disciplinary action is not being taken against persistent offenders	1. Email controls in place as mandated by policy. 2. Protocol to facilitate communication with patients via email, at their request has been implemented for when MIMESweeper is activated to block rather than monitor. 3. The Information Governance coordinator has reported an observed reduction in incidents .This is felt to be attributable to the active awareness campaign and mandatory training programme.

Risk 21 2768 **Risk to pathology services from East of England SHA's pathology transformation project which aims to consolidate pathology services** **Risk Owner - Director of Finance**								**Risk Target: 4**
Relating to Objectives –			**Links to Corporate Risks –**					
Relating to CQC outcome –								
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 4x3 12**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Risk of service viability if GP services are no longer provided within the Trust. Possible financial loss if Consolidated Pathology Services (CPS), of which WHHT is a partner, becomes a GP hub.	1. Active membership of CPS Steering Group. 2. Early assessment of risks and issues. 3. Weekly WHHT project group meetings 4. CPS operational meetings 2 - 4 weekly 5. Pathology Board meetings 2 monthly 6. Quarterly divisional performance review	(+) Full commitment to project by member Trusts. (+) Participating Trusts have agreed a Memorandum of Understanding and a Joint Venture Agreement has been drafted. (+) Formal structured meetings taking place rotating across sites with agenda and minutes. (+) Project manager in place to lead project across consortium. (+) Consultants supporting development of bid. (+) ITT submitted in line with SHA deadlines.	**4x3 12**				**CGAPS** 1. Lack of resource to undertake volume of work within timescale set by SHA. 2. Timescale set was very tight. 3. PCT/CCG views not clear.	1.Outline Business Case submitted 14 March and extraordinary meeting of Board reviewed associated documentation and agreed next steps. 2.Trust in dialogue with SHA. 3. Commercial and financial external support in place.

Risk 22 2828 – The Trust's DATIX system functionality and ease of use is being affected by the need to upgrade server and software. Risk Owner - Director of Patient Safety, the Medical Director: Responsible Manager: Assoc Director of Clinical Governance and Risk								**Risk Target: 5**
Relating to Objectives – Provide Safe Patient Care							**Links to Corporate Risks/CQC Outcome 16**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr1 5x3 15**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Will compromise reporting of incidents, risks, complaints and PALS referrals. This poses a risk to the Trust's ability to ensure timely reporting, learning and improvement from incidents, complaints, claims risks and PALS referrals. An adjacent impact is the slowness of the system takes more time than necessary for staff to utilise the system.	Risk Management Strategy sets out requirements for reporting risks; Serious Incident Policy, Claims and Complaints Policies identify requirements.	(+) Within reporting activity for Trust of this size (-) High number of WACS risks unapproved and slowness of system making it difficult to reduce number with any pace. (-) Doctors' reporting is low and they report this is due to slowness of system and their lack of time. (-) Delays continue in uploading clinical incident data from clinical divisionsto NRLS, attributed to delays in approvals, attributed to unwieldy system.	**5x3 15**				**CGAPS:** 1. DATIX system not owned within overall IT system management, therefore not included in IT server upgrade plans. 2. Inadequate local budget to support server and software upgrades that are necessary to improve user experience.	1. DATIX not included in server virtualisation project and discussions underway to ensure it is. 2. Server virtualisation on hold pending scoping exercise. 3. Raised with information team that DATIX should be part of data warehouse to ensure consistency of reports. ***4. Channel3 review will inform priorities for short term investment pending longer terms solutions to Trust IT.***

Risk 23 2786 Enhanced CRB checks and safeguarding concerns Risk Owner - Director of Workforce and Director of Nursing							**Risk Target: 4**	
Relating to Objectives – 1. Provide safe patient care							**Links to Corporate Risks – Relating to CQC outcome – 12**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**4x4 16**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: Safeguarding children remains high on the political and national agenda; any adverse publicity caused by an incident involving a member of staff is highly likely to reflect badly on the Trust, particularly if it was revealed that the appropriate background checks had not been carried out. Patient safety is paramount; however the potential risk to the Trust's reputation is significant.	1. All staff commencing in post after 2002 have had the appropriate CRB check as part of the recruitment procedure 2. A phased action plan has been devised which breaks down staff groups that have no CRB check on record into 3 initial phases	(+) action plan in place (-)Trust staff who have been CRB checked since 2002 have never been rechecked. (-) evidence of dismal of staff and investigations under disciplinary procedure and professional conduct hearings i.e. NMC. (+)The Trust has a Recruitment and Selection Procedure in place which includes a CRB check on commencement of employment for all staff working directly with patients, in line with NHS regulations. (+) An enhanced check is carried out for staff that have regular contact with children (the Trust procedure defines regular as more than 50% of their role).	**4x4 16**				**cGAP** - A large number of clinical staff employed across the Trust before 2002 have no Enhanced Criminal Records Bureau Check (CRB) on record. **cGAP** - The Trust does not currently have a 3 year re-check policy	Phase 1 involves CRB checks on High Risk staff without a CRB inc Paediatricians & Children's outpatients - this has started 2. Phase 2 is to target the "lower risk" staff inc A&E, ITU etc - currently finalising the names 3. Phase 3 involves a rolling programme for all staff involving a 3 yr - check' policy to prevent substantial time lapses in CRB checks - needs to be confirmed including costs.

Risk 24 2210 Delayed Discharge from ICU Risk Owner - Chief Operating Officer							**Risk Target:4**	
Relating to Objectives – 1. Provide safe patient care							**Links to Corporate Risks – CQC Outcome 4**	
			Residual Score				**Qtr1 I x L**	
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 I x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: 1. Failing to meet guidelines that patients should be bedded on a ward within 4 hrs of being officially 'wardable' – any longer than this is counted as a delayed discharge (DDC). NICE CG83 ' critical care rehab' sets out standards for rehabilitation following critical care admission – Delaying discharge from ICU prevents this occurring.	1. every DDC is reported as an adverse incident 2. Close working with bed managers to understand the impact of not freeing beds to ICU patients Night time capacity form filled in with patients to discharge and 48 hrs predicted given to bed management team. 3. Working with the DoN to implement WHHT targets for discharge – agreed interim target of 24hrs	(+)Not reflected in complaints (-)Numbers steadily increasing month on month (-)Increasing numbers of patients DC directly to home (-)Patients self discharging (-) Patient experience (-) Patients/ relatives raise issues around delayed discharge via PALS	**4x4 16**				**cGAP** - lack of understanding of the patient flow from the bed managers **cGAP** - One wardable ICU is not an appropriate place for patients to be.	1. Addressed in the Quality schedules 2. Capacity to admit critically ill patients within 4 hrs 3. No night time discharges 4. Raise the profile of critical care. 5. Numbers of delayed discharges have increased due to the seasonal pressure being felt throughout the Trust. 6. Issues around privacy and dignity as well as the single sex accommodation guidelines .

Risk 25 2755 Replacement of the CT Scanner Risk Owner - The current CT scanner at Hemel Hempstead is 11 years old and at high risk of breakdown – parts availability is reduced due to scanner past its useful life (7 – 10 years).							**Risk Target: 5**
Relating to Objectives – 1. Provide safe patient care			**Links to Corporate Risks – Relating to CQC outcome**				
			Residual Score				**Qtr1 I x L**
Consequence (What would be the impact if this occurred?)	**Key controls in place** (How are we managing the risk? What is in place to prevent risk from occurring?)	**Key assurances in place** (Who is the assurance provider and what do they do?) Positive (P) – Negative (N)	**Qtr 1 x L**	**Qtr2 I x L**	**Qtr3 I x L**	**Qtr4 I x L**	**Gaps in Control (C) / Assurances (A)** (What are the gaps in our controls / assurance?)	**Actions and Action Progress** (What further actions do we need to improve controls – Monthly update on progress of actions)
Consequence: 1. No alternative scanner at Hemel resulting in interruption of services and a risk to patient safety as a consequence of delays (current 2 week wait likely to increase to 6 in the event of breakdown). **2.** Image quality deteriorating due to age. (4 slice scanner – old technology. New scanners are 16 and 64 slices). Patient choice is likely to be an issue – there is more diagnostic information available on the newer generation scanners. **Clinical Effectiveness:** Higher risk of missing pathology on older technology scanners.	There is only one scanner at Hemel. The only controls relate to contingency planning arrangements developed should the scanner break down.	P = Scanner hitherto very reliable – one 3 day period of breakdown since 1st January – but service disruption significant over the 3 day day outage period.	**5 x 4 = 20**				**CG** – lack of easy availability of alternative scanner on Hemel Site because of reductions in mobile fleet. **CG** – 6 to 8 lead in period for replacement scanner.	Business Plan produced for Trust Board with option appraisal. – completed June 2011 but not accepted as further work required linked to Divisional Strategy. Radiology Services Manager has been asked to produce paper with regard to acquiring a mobile CT scanner at HHGH/SACH – completed September 2011 – reviewed and concluded this was not a solution**.** Radiology Services Manager has been asked at Clinical Support ISE to escalate risk to Trust Board - **completed and reviewed at May IRGC – approved for BAF.**