HSCIC Corporate Risk Register as at 6th January 2014

Risk ID	Risk Description	Risk Impact 1-5	Risk Likelihood 1-5	Risk Exposure 1-25	New RAG	Risk Owner	Risk Mitigation & Intended Impact	Action Owner	Action Progress	Expected Completion Date	Residual Risk Exposure	New Residual RAG
1) STRATEGIC RISK												
1	Under the 2012 Act, the HSCIC has a number of unique powers in data collection and systems delivery for the system. The ability to build trust and secure this unique position into the future it is essential that we establish our reputation on all core functions, including data quality assurance and management of burden, and at the same time do not damage our reputation by failing in one of our key areas. These include the ability to handle personal confidential data, the ability to demonstrate competence as a Safe Haven and to be an exemplar of cyber security.	4	4	16	21	CEO	a. HSCIC strategy to assert our role and functions	Mark Davies	a. Starting to assert ourselves on key issues, but work in progress b. Progress on policy documents and aim to complete by end of year c. Developing relationships and processes, and work in progress.	On-going	3/3 9	12
							b. Continue to undertake rigorous audits of controls and procedures.	Mark Davies	b. Progress on policy documents and aim to complete by end of year	On-going		
							c. Work with ISCG and other organisations to lead a system-wide approach to quality assurance and security issues.	Mark Davies	c. Developing relationships and processes, and work in progress.	On-going		
2	There is a risk that the organisation does not have the capacity to deliver commitment programmes and services, new strategic commitments and transformation activities impacting the ability of the organisation to deliver on its strategy	4	5	20	24	Rachel Allsop	1. Develop a set of Transformation projects and plans	Rachel Allsop	1. Initial set of initiatives produced and considered by Transformation Programme Board in July. Full set of projects and initial plan approved by the September Transformation Programme Board. Detailed planning for individual projects in progress	30-Jan-14	3/3 9	12
							2. Undertaken tactical review of current vacancy and recruitment approach bringing together ZBR, LSP consultation, confirmation of recruitment controls, future years financial headroom, review of recrutment processes and agree a series of mitigating actions	Rachel Allsop	2. Agreed that Transformation Projects will undertake checkpoint by the Programme Board including resource requirements and impact on the organisation. Plan to consolidate into initial view by end December	30-Jan-14		
							3. Develop a workforce response to the HSCIC strategy	Rachel Allsop	3. To be devloped for December HSCIC Board	30-Jan-14		
							4. Develop and progress the Recruitment and Talent Attraction transformation project for medium to longer term requirements	Rachel Allsop	4. Project to be defined by end December 13. Recruitment Framework to be developed by March 14 for implementation through 14/15	30-Jan-14		
3	Unless HSCIC's role is clear to the whole Health and Social Care system, there is a risk that other organisations will persist on duplicating HSCIC's collection role for the system. This could undermine HSCIC's role, erode confidence and further lead to reputational risk	3	3	9	12	CEO	a. Assert our position through our Sponsor and other dialogue with these bodies;	Mark Davies	a. Good relationship developing with sponsor; a. Taking initiative to be put on front foot with key issues (e.g. ZBR)	On-going	2/1 2	2
							b. Collaborate with our partners to enable us to understand and respond to their requirements	Mark Davies	b. Starting to work effectively at all levels (e.g. review of business case process, business planning)	On-going		
2) FINANCIAL AND CONTROL RISKS												
4	There is a risk that a failure to secure the full amount of budgeted income leads to ineffective financial management, including a failure to fund priority work, and a loss in HSCIC credibility	5	3	15	19	Carl Vincent	1. Raise awareness to ensure that all areas of the business understand importance of securing income, and having an early clear and up to date understanding of expected income	Carl Vincent	The issue has been discussed at EMT, and finance business partners have attended key team meetings to raise the profile of the issue. It is now better understood as an issue, but we need to keep under review to ensure it is given sufficient priority	Complete	3/2 6	8
							2. Create and maintain a central record of budgeted income, along with supporting information, to enable tracking	Carl Vincent	We have created an Income Schedule covering all budgeted income and are in the process of completing missing data and compiling supporting documentation (MoUs, SLAs etc.)	30-Jan-14		
							3. Conduct an internal review across the organisation of the budgeted income for 2013/14, and reforecast as necessary	Carl Vincent	We are in the process of detailed reconciliation between Zero Based Review templates and the Income Schedule and investigating any changes in the forecast income. In addition, due to the monthly reconciliation with Budget Hollder Forecast Files we identify any changes (or potential changes) to forecast income each month end	30-Jan-14		
							4. Secure commitments from the senior finance team in the funding organisations (DH and NHS England) to the funding promised at the start of the year	Carl Vincent	DH sponsor team and NHS England have agreed this in principle but having the agreements in place will take until the start of the next financial year	Mar-14		
							5. Reduce risk in future years by putting in place alternative arrangements so that the majority of the funding is secured at the start of the year as part of business planning. The aim is to have an agreed business plan with DH that includes deliverable and funding for the vast majority of the DH commissioned work, and a similar SLA-type arrangement with NHS England that delivers a similar outcome	Carl Vincent	DH central finance and DH sponsor team are sympathetic to this objective, and early discussions with the business leads within the NHS England P&I Directorate suggest they may be willing to follow this approach. We have so far only had very provisional discussions with NHS England finance team	31-Mar-14		
5	There is a risk that delays to major programmes pushes unaffordable costs into future years. Whilst most of the expenditure is accounted for by the DH, it has potentially serious implications for investment in NHS and social care IT, and will undermine the credibility of HSCIC capability in a key delivery area that	3	5	15	22	Carl Vincent	1. Produce an up to date forward forecast for the next 5 years for all programmes (money accounted for by the DH and HSCIC expenditure), setting out extent to which expenditure is contractually committed, etc	Carl Vincent	Action completed. Alongside programme information we used the forecasts as the basis for the Star Chamber to review the affordability of th programmes.	Complete	3/4 12	18
							2. Develop the reporting mechanism to enable DH and the HSCIC to more effectively monitor the expenditure on programmes paid for from DH programmes	Carl Vincent	Have agreed in principle to work with DH Group Finance and DH sponsor team	Jun-14		
							3. Improve understanding and visibility of costs and likely funding envelope	Carl Vincent	We have established good working with relationships with DH finance and jointly agree a monthly finance report. We have also started to report programme expenditure and forecasts to the EMT and plan to do this in summary form to the HSCIC Board (whilst having to take account of commercial sensitivity in the public board meeting). We have started a process of engagement with the business managers within the P&I Directorate of HSCIC and with the DH sponsor team. We ultimately need to achieve a position where ISCG have full sight of a robust affordability position on an on-going basis	On-going		
							4. Improve forecasting so that it is based on realistic and robust assumptions, and improve reporting to the HSCIC Board and ISCG in particular, so that the key decision making forums use realistic forecast expenditure profiles by individual programme to inform decisions.	Carl Vincent	The HSCIC finance teams understand the need for robust forecasts based on realistic assumptions but we need to do much more work to establish this principle with the SROs	On-going		
4) INFORMATION GOVERNANCE RISK												
7	Establishing a legal gateway for data flows being required by commissioning groups delays the HSCICs ability to meet the requirement and has a reputational impact.	4	4	16	21	Rob Shaw	1. Work with NHS England and DH to ensure an appropriate approach which will support business continuity can be found. 2. Establish communications channels with commissioners.	Rob Shaw	NHS England are still drafting the Directions for local dataflows which we are being consulted on. They have sought s251 support to allow data to be used for Risk Strat purposes and are awaiting the decision on their application. They are drafting further guidance on Invoice Validation which is due out in the next week or two	30-Jan-14	4/3 12	17
8	Personal error, failure of HSCIC control systems, or a cyber attack results in loss of personal identifiable (or other very sensitive) data	5	3	15	19	Rob Shaw	1. Continue to undertake rigorous audits of controls and procedures. 2. Review cyber security controls 3. Comms programme for staff to remind and reinforce their responsibilities 4. Ensure internal audit programme covers appropriate areas 5. Consult with other government departments to ensure appropriate steps being taken 6. Provide widespread staff access to Confidentiality Guide for confidential information	Rob Shaw	Merger of policies and procedures for predecessor organisations being undertaken Plans for cyber security review in pace: results to be reported to October HSCIC board consideration of need for Information assurance committee of the HSCIC board internal audit programme agreed with internal auditors - results considered by assurance and risk committee. consultation with other government departments commenced	30-Jan-14	5/2 10	15
9	A failure in information governance elsewhere in the H&SC system leads to a loss in sensitive data and impacts on HSCIC reputation	4	3	12	17	Rob Shaw	1. Ensure that Code of Practice and other advice and guidance are kept up to date and checked for consistency at regular intervals 2. Provide helpline for health and social care customers to seek advice 3. Consider options for audit 4. Ensure internal audit programme covers appropriate areas 5. Consult with other government departments to ensure appropriate steps being taken 6. Provide widespread staff access to Code of Practice and Confidentiality Guide for confidential information	Rob Shaw	1. Plans are in place to allocate specific responsibilities 2. A contact number has been provided and calls are being monitored by a specific resource and confguide@hscic.gov.uk mailbox set up as an alternative communication channel 3. 4. 5. A team is being developed which will have responsibility for consulting with government departments to ensure appropriate steps are being taken. A stakeholder group from multiple government departments (and the independent sector) has been operational throughout the development of the Confidentiality Guide and still operates as a communication channel, and to support the development of the Code of Practice. Comms and media activities include a calendar of presentation slots at both local conferences and large-scale national conferences (eg Health Innovation Through Technology Expo), press releases, a formal launch by Secretary of State, Dame Fiona Caldicott and Kingsley Manning on 12 Sept and associated media 6. Comms and media plans and strategies are operational for the Confidentiality Guide and are in place for the Code of Practice (yet to be produced). A web version and paper copies have been produced, alongside a suite of promotional materials (posters, leaflets etc). Furthermore, stakeholders from the independent sector who have no obligation to have regard to the code have asked if they can publicly endore the Guide and we are working with stakeholders to facilitate wider access for their staff	1. Complete 2. Complete 3. 4. 5. Jan-13 6. Complete	3/2 6	8
4) OPERATIONAL RISK												

Risk ID	Risk Description	Risk Impact 1-5	Risk Likelihood 1-5	Risk Exposure 1-25	New RAG	Risk Owner	Risk Mitigation & Intended Impact	Action Owner	Action Progress	Expected Completion Date	Residual Risk Exposure	New Residual RAG
10	A catastrophic failure of a business critical system (e.g. N3 or Spine) creates the potential for significant impact on NHS operational services and patient care. Technical / Business Impact: Clinical Safety compromised – Clinical information may not available in a timely manner causing various impacts including: • Radiology, pathology, etc and procedure requests revert to manual process. • Results, clinical decision making, and discharge comms, being delayed. • Creation of duplicate numbers, and correspondence with no NHS number. • Discharge summaries delayed. • CAB users will not be able to cancel and re-book appointments • No real time bed state not sure where patients are. • Cannot check infection control flags. • No generation of NN4Bs. • Inability to administer patients and manage appointments and clinics. Scale of outage –the greater the number of Trusts affected, the higher the impact, paying particular attention to Trust types, e.g. Acutes etc. Duration - anything where the Recovery Time Objective cannot be achieved becomes really high impact. Day of the week / time of event - an outage impacting GP systems on a Sunday will be less significant than one occurring at 0830 on a Monday morning. Reputational damage – serious incidents would generate media interest Business/Technical impacts linking to other risk areas IT Security –there is potential for a significant impact on IT Security, e.g. loss of Patient Identifiable data. Financial Impact – potential for high recovery costs Failure to meet Legislative and Regulatory obligations (e.g. Data Protection Act)	**5**	**2**	**10**	**15**	Rob Shaw	High Availability Infrastructure 1. To maintain business continuity and meet expected service levels, business critical systems are designed around high availability infrastructure, providing extensive levels of resilience and redundancy to maintain service continuity and availability of the services. Monitoring tools are deployed throughout the infrastructure allowing service providers to undertake proactive monitoring of services, detect potential issues and resolve them before they become service affecting.	Rob Shaw	We now have Transformation Board approval to proceed with the SIAM model which standardises how we manage service integration within HSCIC. Rob Shaw is also recruiting an experienced Head of Live Operations to ensure we have all systems in place to support running the live service operations when we go live with repacement solutions such as Core Spine. Advertising for this role closes 25/10/13		**4/2 8**	**13**
							Dual site service deployment 2. To maintain Disaster Recovery requirements, business critical systems are designed around two site strategies - primary Data Centres where live services are deployed are supported by high availability infrastructure, providing extensive levels of resilience and redundancy to maintain business continuity of the services. These are supported by Secondary Data Centres with appropriate infrastructure in place to enable recovery of all of the service in the event of a Disaster. Monitoring tools are deployed throughout the infrastructure allowing service providers to undertake proactive monitoring of services, detect potential issues and resolve them before they become service affecting.	Rob Shaw				
							Regularly Reviewed and Tested Crisis plans 3. Business continuity and disaster recovery plans are in place for business critical services. These are reviewed on a six-monthly basis. Underpinning the business continuity and disaster recovery plans are detailed technical recovery plans.	Rob Shaw	Business Continuty plans are in place for both Leeds and Exeter and are reviewed on a monthly basis as a standing item in the monthly management meeting.	On-going		
							Agreed Recovery objectives 4. Contractual Recovery Time and Recovery Point Objectives are in place for supplier provided business critical services.	Rob Shaw				
							Resilient HSCIC and Supplier support functions 5. To underpin the delivery of the critical services, suppliers and the HSCIC have robust Service Management Organisations based on ITIL (Information Technology Infrastructure Library) good practice, which include Service Desks with established processes for incident management and escalation in the event of a high severity incident. Tested business continuity plans are in place for these support functions.	Rob Shaw	A number of service desk disaster recovery tests have been run successfully in the last 6 months. There is a rolling programme and all service desks carry out this exercise.			
							Testing Programme 6. A programme of disaster recovery testing is undertaken for business critical services. This takes the form of non-functional testing of disaster recovery and resilient solutions prior to go live and after significant changes to infrastructure, live operational testing, and simulated walkthrough testing.	Rob Shaw				
							Assurance Programme 7. On-going programme of assurance of the provision of suppliers' business continuity and disaster recovery solutions.	Rob Shaw	There is an ongoing rolling programme of assurance for suppliers services and their disaster recovery. Seven tests have been completed successfully this year and there are scheduled plans for the remainder within year.			
13	There is a risk that as public awareness of care.data increases, the HSCIC Leeds Contact Centre and the Redditch Call Centre will receive more calls from the public/Health and Social Care staff than are forecasted resulting in a deterioration of service.	**4**	**3**	**12**	**17**	Max Jones	1. Monitor call loads until the New Year with a view to closing this risk then.	Max Jones until care.data Programme Director appointed.	1. Resource modelling has been completed and funding and procurement route has been agreed with NHS England. The service will be managed via a SLA between HSCIC and NHS England (due to be in place 15/11/13). We are confident that we can handle any incrreased call load based upon our modelling and experience. Likelihood reduced to 3	On-going	**3/3 9**	**12**
5) PROGRAMMATIC RISK												
11	Failure in delivery of HSCICs support for DH in the remaining LSP commitments, exit, and transition leads to non-delivery of benefits and/or NHS bodies losing critical systems.	**5**	**3**	**15**	**19**	Tom Denwood	1. LSP Delivery Assurance Review conducted and completed by DH to quantify issue and make recommendations for mitigation- COMPLETE 2. Appointment of National LSP Programme Director, LSP Benefits Director, CSC and BT Programme Directors, and specific Exit Managers for both BT and CSC Programmes- COMPLETE 3. Revised Programme Governance, including cross-Government Exit Board chaired by DH LSP SRO, in place- COMPLETE 4. HSCIC successfully support closure of CSC PACS contract on 30/06/13- COMPLETE 5. Draft MOU in place between DH and HSCIC to formalise HSCIC support- COMPLETE 6. Support DH LSP SRO get agreement from Ministers on funding principals of exit - COMPLETE FOR BT, NOT STARTED FOR CSC	Tom Denwood	1. Work with Sponsor branch and NHS England to formalise links between LSP Exit and Safer Hospitals Safer Wards / Technology Fund - WIP 2. Work within customer Trusts in NME to support them to form consortia - WIP 3. Explore opportunity and appetite for HSCIC to host Trust funded framework contracts (or procurement ecosystem) to derisk Exit- WIP 4. HSCIC to work with customer Trusts to understand target plans/systems (as procured)- WIP 5. HSCIC to work with suppliers to negotiate suitable exit support- WIP with BT. NOT startered with CSC. 6. HSCIC to manage exit slot plans on behalf of Programme Boards- NOT STARTED	1. Complete 2. Complete 3. Complete 4. Complete 5.Complete 6. Jul-16	**3/3 9**	**12**
12	There is a risk that there will not be business case coverage in place to ensure continued delivery of the Electronic Prescription Service from 01 April 2014, which is when the current EPS Release 2 business case ends. This could result in benefits not being fully realised and negative HSCIC reputational damage.	**4**	**5**	**20**	**24**	James Hawkins	1. Tolerance Exception Report addressing programme timescales raised to HSCIC IPB - COMPLETE April 13 2. Action plan raised to ETP programme board - COMPLETE 30 May 13 3. New Work Submission approved 08 July 13 - COMPLETE 4. Project brief and strategic justification to be discussed at September programme board	James Hawkins	1. Complete 2. Complete 3. Complete 4. Project Brief approved at October HSCIC Portfolio Board allowing the programme team to develop a two year business case extension. It is expected that a draft Extension Business Case will be available for SME review in January 2014	1. Complete 2. Complete 3. Complete 4.Jan-14	**4/3 12**	**17**
14	There is a risk that the HSCIC is unable to reach financial agreement on the budgetary shortfall, legacy liability if any, and exit costs for the services that are expected to transfer from NHS Direct. However, there is an assumption within the 'system' that HSCIC will still accept the transfer of the services regardless of the financial position.	**4**	**3**	**18**	**18**	James Hawkins	1. Undertake required due-diligence to identify exact costings to transfer and successfully delivery the services for the comissioning period, including any legacy liability and breakage costs. 2. Work with commissioner to agree level of funding required for each of the services 3. DH, NHSE, TDA, NHSD and HSCIC finance leads to discuss handling of liabilities and decommissioning costs and produce a paper on the future liabilities and costs, and risks, for considerationat the Closure Board meeting on 23/12/13. 4. Programmes Delivery Director to present services transfer position to the HSCIC Board on 04/12/13, including highlighting financial risks. 5. Programmes Delivery Director to present progress on conditions stipulated by the HSCIC board at the next board mid-Jan 2014	James Hawkins	1. Workstream leads continue to determine required costs for the services 2. In parallel to action 1. workstream leads are validating assumptions and required costings for the services with NHS England 3. Ongoing 4. Complete 5. A paper will be submitted to the board	1. 31/12/13 2. 31/12/13 3. 23/12/13 4. Complete 5. 15/01/14	**4/1 11**	**11**

HSCIC Corporate Issue Register as at 6th January 2014

Issue ID	Issue Description	Issue Impact 1-5	Issue Owner	Issue Mitigation & Intended Impact	Action Owner	Action Progress	Expected Completion Date	Residual Issue Exposure
Issue1	There was a requirement for Data Management Integration Centres to become part of HSCIC from April 2013. It is a highly complex environment and much has been achieved but future requirements are still evolving.	**5**	Max Jones	1. Legal assurance and information governance assurance being sought from lawyers and internal audit.	Martin Dennys	1. Complete	Complete	**4**
				2. The Secondment Agreement agreed between the BSA, the HSCIC and NHSE w/e 5 April. Secondment Letters for permanent staff issued to CSU HR Leads for onward distribution w/e 5 April. Plans for induction well underway and instructions will be issued to staff no later than 12 April 2013.	Martin Dennys	2. Complete.	Complete	
				3. Work is on-going to partially re-assign contracts to enable contingent staff or other service provider agents involved in the delivery of the Data Service for Commissioners to continue to do so.	Eve Roodhouse	3. Complete.	Complete	
				4. Contractors (51 staff) are also being seconded into the DSC ROs to cover vacancies. Agreement finalisation and signature with NHS England nearing completion.	Eve Roodhouse	4. Complete	Complete	
				5. Seconded staff and contractors are working part-time under DSC RO governance and part time under CSU governance. The DSC RO design for April 2014 onwards will aim to resolve this.	Martin Dennys	5.NHS England requirements expected December 2013, HSCIC options for solution expected March 2014	Mar-14	
				6. NHS England announced that staff performing Invoice Validation are also to be seconded to the HSCIC. This requirement has only been accepted to Oct 2013. NHS England and CSUs to design and implement a future solution.	Martin Dennys	6. NHS England is confirming legal guidance on whether and how Invoice Validation can be performed within the CSUs and CCGs, therefore negating the requirement to second staff for Invoice Validation activities	Jan-14	
				7. The requirements for DSC RO from April 2014 have yet to be agreed with NHS England. A mandate from NHS England and an options analysis is needed to advise any decision.	Martin Dennys	7. NHS England are behind on this action - requirements expected December 2013	Jan-14	
Issue3	The business case for the delivery of 'care.data' is in development, and as such funding for the programme is uncertain. Some aspects of the programme were already funded through other routes for FY13/14 so work can continue but planning for FY14/15 may be hampered if the business case is not finalised and approved in the coming months. The potential impact is delays in delivering the care.data platform (and subsequent data set landing on it) and means that the programme is effectively working at risk	**5**	Max Jones	1. The mandate for the programme was approved at the June Prtfolio board and a Programme Brief will be submitted for the Portfolio Board alongside formal closure requests for ODP and NIRS (approach agreed with Tom Denwood). This will enable care.data to be included on the single Portfolio. Governance arrangements are already established (programme board also acts as a sub-group of the ISCG) and Chris Outram (NHS England) is SRO	Eve Roodhouse	1. The brief is in development and will be submitted to the November Portfolio Board for approval	Jan-14	**3**
				2. Develop and gain approval for SOC	Eve Roodhouse	2. The SOC (HSCIC Strategic Capabil/ity, covers infrastructure for and delivery of care.data) has been developed and is currently in the approvals process with the intention to submit it to the Nov ISCG for approval	Jan-14	
Issue4	The roles of the majority of staff transferred in from SHAs are yet to be determined as they depend on HSCIC organisational direction on local teams. This is compounded by the issue that within NHS CFH there were staff who became under-utilised on DHs signing of the CSC Interim Agreement on 31/08/12 but because of pending transition into HSCIC, the underutilisation issue was not addressed. ISSUE: Baseline audit identified of the 280 staff who transitioned into the LSP area, 55% work on LSP delivery, 26% on other HSCIC delivery, and 19% other commissions. All staff however currently reside in the LSP area within HSCIC and arguably need to be redeployed to a more appropriate host within HSCIC or into a local delivery capability.	**5**	Tom Denwood	Managed through LSP Directorate Transformation Programme (will launch a formal staff consultation in Summer2013 on agreed blueprints) with escalation to HSCIC Transformation Programme as needed. There are a number of staff that are underutilised providing poor value to the taxpayer, and also demotivated. On a tactical basis, underutilised staff given opportunity of being deployed via a tactical work package process. TUPE constraints apply.	Tom Denwood	1. A local teams options paper on local teams was presented for feedback at HSCIC Transformation Board on 21/06/13 and 31/07/13. CLOSED 2. Blueprint for programme teams agreed and ready for consultation completed on 03/07/13. CLOSED 3. Start of two phase consultation (start dependent on approval of organisational change policy). Informal pre-consultation completed. Formal collective consultation started 7/10/13 - CLOSED 5. Paper to be submitted to future HSCIC Board. HSCIC strategy confirmed as not including local teams provision for NHS England. 23/10/13- CLOSED 6. Transformation consultation expected to be complete by 6.11.13. WIP 7. Current staff utilisation addressed by interim roles and work packages. Future blueprint will determine optimal design for LSP delivery. - WIP 8. Transformation also to effect direct transfers where staff should sit in other directorates. - WIP 9. Any staff not successful in securing a role in LSP DD will be supported through process to secure suitable alternative employment within HSCIC. - NOT STARTED 10. Options to mitigate redundancies under consideration - WIP	On-going	**3**
Issue7	The Government ICT Strategy calls for the NHS to use the Public Services Network (PSN). The PSN for Health project has reached a point where issues with the maturity of the PSN means that it will not meet the requirement of Health and Social Care and demand a review of proposed replacement approach.	**4**	James Hawkins	1. Revisit project assumptions for PSN for Health, especially in the context of the Outline Business Case. 2.Work with NHS England to determine suitable approach with NHS. Continue to engage with Cabinet Office to resolve areas of concern with PSN. Extend N3 to provide a live service whilst the issues are resolved.	James Hawkins	1. The issue has been raised with the SRO and an action plan is being developed. 2. Development of an operating model, baselining current operating model and development of gaps in PSN that would need to augment. 3. Engagement with PSN Cabinet Office design team to develop requirements.	Jan-14	**3**
Issue5	Income tax on travel. Employees working regularly out of more than one office have liability for income tax on travel expenses.	**4**	Rachael Allsop / Carl Vincent	1. A baseline audit identified that of the 280 staff who transitioned into the LSP area, 55% of staff work on LSP delivery, 26% other HSCIC delivery, and 19% other commissions. All staff however currently reside in the LSP area within HSCIC and arguably need to be redeployed to a more appropriate host within HSCIC. Issues are either being managed through the LSP Directorate Transformation Programme, or for those issues that are a corporate decision by escalation to the HSCIC Transformation Programme. The key decision is whether HSCIC wishes to host Local Teams are part of its future business strategy.	Rachael Allsop / Carl Vincent	Remaining outliers being identified and action plans being developed	Jan-14	**3**
				2. KPMG have provided definitive advice in conjunction with HMRC - all new appointments will be made in the full knowledge of this issue.	Rachael Allsop / Carl Vincent	1. Interim note placed on intranet setting out basic position for employees. 2. Final policy under development.	Complete	
Issue10	Advice from ONS on publication of information that includes ONS data adversely impacts HSCIC publications and ability to include small numbers.	**4**	Rob Shaw	1. Undertake an internal assessment of anonymisation levels required using the HSCIC standard. 2. Provide proposals to ONS for discussion regarding disclosure levels.	Rob Shaw	1. Assessments being conducted. 2. Discussions with ONS commenced.	Jan-14	**3**
Issue11	HSCIC is directed by the Secretary of State to operate the NHS Choices service from 1 August 2013 thru to the 31st March 2014. This required the TUPE transfer of circa 145 staff from Capita PLC. The costs of TUPE and operation of the service through to 31 March 2014 will be met from within the existing NHS Choices programme budget.	**4**	James Hawkins		James Hawkins	New issue from risk 6. Dean White: 20/12/13: There is acceptance by NHS England and DH Sponsor that the NHS Choices service will retained by the HSCIC until at least March 2015, allowing time for the HSCIC to develop the business case for the long-term provision of NHS Choices. DH has confirmed that no indemnity will be provided, but ISCG Investment Approvals group (19th Dec) in considering the strategic outline case for NHS Choices highlighted the affordability impact on the HSCIC 2014/15 Admin budget. ISCG Chair has requested that DH group finance to seek a further years dispensation from HMT in continue to treat the cost of NHS Choices as DH Programme spend.		

Impact Guide						Likelihood Guide
Score	**Cost**	**Quality**	**Schedule**	**Reputation**	**People**	
1	Directorate: <£500k Programme: <£100k Project: <£10k -or- Up to 1% of budget	Minor impact on single functionality/ capability -or- Minor weaknesses (observation) identified at Gateway review or audit	<1 week delay -or- Impacts project non-critical path milestone (within tolerance)	Requires Deputy Director's/ Project Manager's response -or- Results in local news coverage	Will indirectly lead to multiple minor injuries -or- Only affects an individual member of staff	<10% chance of occurrence -or- Has not occurred within last 3 years
2	Directorate: <£1m Programme: <£500k Project: <£50k -or- Up to 3% of budget	Failure to achieve a single deliverable to time/ cost/ quality -or- Minor impact on multiple functionalities/ capabilities or moderate impact on single functionality/ capability -or- Moderate weakness (GREEN) identified at Gateway review or audit	1-2 weeks delay -or- Impacts project non-critical path milestone (out of tolerance)	Requires Director's/ Programme Manager's response -or- Results in regional news coverage	Will directly lead to single minor injury -or- Will indirectly lead to a single fatality -or- <5% staff/ public affected	11-33% chance of occurrence -or- Has occurred within last 3 years and could occur again
3	Directorate: <£10m Programme: <£1m Project: <£100k -or- Up to 5% of budget	Failure to achieve multiple deliverables to time/ cost/ quality -or- Moderate impact on multiple functionalities/ capabilities -or- Severe weaknesses (AMBER) identified at Gateway review or audit	3-5 weeks delay -or- Impacts project Critical Path milestone	Requires Executive Director's response -or- Results in national news coverage	Will directly lead to a single severe injury -or- Will directly lead to multiple minor injuries -or- Will indirectly lead to multiple fatalities -or- 6-10% staff/ public affected	34-67% chance of occurrence -or- Has occurred in last year and could occur again
4	Directorate: <£50m Programme: <£5m Project: <£500k -or- Up to 7% of budget	Failure to achieve a single key deliverable to time/ cost/ quality -or- Major impact on single functionality/ capability -or- Critical weaknesses (RED) identified at Gateway review or audit	6-12 weeks delay -or- Impacts Programme non-Critical Path milestone	Requires Chief Executive's response -or- Results in prolonged national news coverage	Will directly lead to a single fatality -or- Will directly lead to multiple severe injuries -or- 11-15% staff/ public affected	68-89% chance of occurrence -or- Has occurred 2 or more times within in last year and could occur again
5	Directorate: >£100m Programme: >£10m Project: >£1m -or- Up to 10% of budget	Failure to achieve multiple key deliverables to time/ cost/ quality -or- Major impact on multiple functionalities/ capabilities -or- Failure to pass Gateway review or audit	>12 weeks delay -or- Impacts Programme Critical Path milestone	Requires Ministerial response -or- Results in international news coverage	Will directly lead to multiple fatalities -or- >15% staff/ public affected	>89% chance of occurrence -or- Has occurred within last 6 months and could occur again

Impact						
5	16	20	22	24	25	
4	11	14	18	21	23	
3	9	10	12	17	19	
2	6	7	8	13	15	
1	1	2	3	4	5	
	1	2	3	4	5	Issues
	Likelihood					