Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Trust Board
1st May 2014

TITLE	**Trust Risk Register**
EXECUTIVE SUMMARY	This report presents the Trust Risk Register as at 24 April 2014. Since last reporting to Trust Board on the 28 November 2013 there have been the following changes to the register: Three risks downgraded.
BOARD ASSURANCE (RISK)/ IMPLICATIONS	The Trust Risk Register report provides assurance that relevant risks have been identified as Trust risks and that mitigating actions are in place. The report contains, the full Trust Risk Register.
LINK TO STRATEGIC OBJECTIVE/BAF	The Risk Register links to all Strategic Objectives.
STAKEHOLDER/ PATIENT IMPACT AND VIEWS	Not assessed and views not taken.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	The Trust Risk Register is required by the Department of Health and is a particular requirement of the NHS Litigation Authority. It is a fundamental operating requirement of Monitor.
The Trust Board is asked to:	The Trust Board is asked to review and discuss the contents of the Trust Risk Register and assure itself that all risks are accurately identified and mitigated adequately.
Submitted by:	Mick Imrie, Chief of Patient Safety / Deputy Medical Director.
Date:	24th April 2014
Decision:	For Assurance

Trust Risk Register

ID	Title	Description	Risk Opened	Risk level (current)	Risk Level Target	Action Plan	Progress	Review date	Monitoring
1268	The Trust exceeds the budget it has assigned for managing penalties	The national contract the Trust holds with its two main commissioners contains penalties. The estimated risk of these penalties is at present £2.6m for readmissions, £2.3 million for NEL and approximately £2 million for other penalties. The risk is that we exceed the budgeted values. The estimates above are to be refined in later versions of this document.	**HIGH** **12** 17/04/2013	**EXTREME** **16** 	**LOW** **3**	1. Development of Dashboards 2 .Daily/weekly/monthly monitoring of targets 3 .Daily operational meetings 4. Weekly Performance meetings 5. Monthly speciality performance meetings 6. Monitoring by Information team/Finance team and Business Development teams	**March 2014** – The new contract for 2013/14 is currently being negotiated. Following conclusion of those negotiations the risk level will be reset.	01/05/2014	Executive Director: Simon Marshall Lead Manager Stephen Hepworth
1129	28 day readmission rate (BAF 4.2) **NB** now measured at 30 day readmission rate	High readmission rate indicative of poor quality. Requirement to reduce emergency-emergency readmissions from 14.5% to 10.6% by quarter 4 2013/14. Loss of CQUIN monies (1.1 million) if not achieved. Reductions will also reduce the penalties estimated to be £2.6m	**HIGH** **12** 31/03/2011	**EXTREME** **16** 	**MED** **4**	Readmission prevention programme being led by Dr D Fluck and supported by the PMO The project in Q1 has been focused on ensuring accuracy of recording of data. In addition a number of patient pathways are being reviewed. Q2 has seen the start of readmission risk stratification (within medicine)and appropriate interventions to prevent readmission	**March 2014** - Q1-Q3 CQUIN target achieved but not for Q4. Project work streams will be carried over to 14/15. However, no longer a CQUIN.	01/05/2014	Executive Lead: David Fluck Lead Manager: Ria Wright
1244	Staff satisfaction (BAF 2.3)	There is a risk that staff satisfaction declines thereby adversely affecting short term performance and long term goals.	**HIGH** **12** 16/11/2012	**EXTREME** **16** 	**LOW** **3**	**November 2012:** 10 corporate commitments (2012/2013) in response to the National Staff Survey (NSS) in place. Divisional and departmental plans (2012/2013) in response to the NSS in place. Robust leadership, engagement and	**March 2014 –** The National Staff Survey results were published in March and cascaded to all staff. Since that time a communications strategy about the Employee Promise and establishing value based behaviours	01/05/2014	Executive Lead: Louise McKenzie Lead Manager: Jules Arnould

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						governance processes and systems in place to monitor progress and improvement.	has been initiated.		
764	Delivery on all Performance Targets. (BAF 2.3)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target.	**HIGH** **12** 12/03/2008	**EXTREME** **16** 	**MED** **4**	**March 2013:** The Trust undertook a significant piece of work during 2012/13 to redesign the emergency care pathway for medical patients. This change formed the basis of the Unscheduled Care Programme and was completed in partnership with the NHS IMAS Emergency Care Intensive Support Team (ECIST). Whilst the Unscheduled Care Programme has delivered improvements in capacity and flow and patient experience, there is still more work to do to bring performance up to the required standard. To determine the work programme for the coming year the management team in the Division of Medicine and Emergency Services has completed a gap analysis to identify any actions outstanding in existing action plans and guidance about best practice.	**March 2014 -** RTT Actions including: - Demand and Capacity Planning, complete in a number of areas but to be rolled out across all specialties - Trajectories developed showing timescale for bringing Trust back into line on waiting time targets - monitoring process developed. -Progress against trajectories regularly monitored and to date is on track delivering specialty recovery as planned. - Staff Training module for 18 weeks and Access Policy has been developed and training schedule underway. A&E 4 hours: Development of revised work plan for A&E: Five work streams focusing on A&E processes, workforce redesign, development of the Acute Hub model, Consultant-led ward care and the Ashford Hospital strategy.	01/05/2014	Executive Director: Valerie Bartlett Lead Manager: Philip Purdy

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1266	Risk of underachieving the Trust's £11.8m Quality and Transformation Efficiency Plans 2013/14 (BAF 4.3)	The Trust continues to develop both its leaders and structures to ensure that divisions and specialties are capable of driving sustained change. The Project Management Office (PMO) is tasked with ensuring that the organisation keeps its Quality and Transformation programme on track and supports the divisions and specialties. By running our performance meetings at the specialty level the Trust ensures that its organisational culture promotes the interests of patients as well as finance and performance targets.	**HIGH** **12** 03/04/2013	**EXTREME** **16** ⇔	**LOW** **3**	A robust Quality and Transformation (CIP) Strategy has been produced and is being implemented. On-going monitoring will continue now, and throughout 2013/14, to ensure that the plans for 2013/14 are robust and monitored to ensure delivery and have strict quality scrutiny, assessment and monitoring. This work will include on-going identification and development of new schemes in order to de-risk the £11.8m CIP target	**March 2014** - Finance Director reports the Risk level for 2013/14 remains the same, although the focus for delivery of CIPs has now shifted to delivery for 2014/15, with the ownership of delivery and risk transferring into the Divisions from 1 April 2014.	01/05/2014	Executive Lead: Simon Marshall Lead Manager: Philip Purdy
1317	The Trust has an overreliance on temporary workforce and in particular agency staff which leads to reduced quality of care and increased expenditure	The trust currently has an overreliance on temporary workforce due to increased activity and escalation, covering junior doctor positions unfilled by the Deanery and due to difficulties in recruiting and retaining staff.	**EXTREME** 16 ⇔	**EXTREME** **16** ⇔	**LOW** **1**	Implementation of a Temporary Staffing Review Board to commence in November 2013 which will incorporate four work streams. 1. Medical workforce planning 2. Governance & control processes 3. Supply 4. HR	**March 2014 –** No change since Feb 2014. **Feb 2014:** Temporary Staffing Review Board approved High level action plan. Specialty level workforce planning being carried out as part of business planning process. A revised set of controls for booking bank and agency in all staff groups have been implemented.	01/05/2014	Executive Lead: Louise McKenzie Lead Manager Colleen Sherlock

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1170	Inadequate quality in performing WHO Safer Surgery Checklist	Repeated audits show that the final check of the WHO Safer Surgery Checklist is done for more than 95% of patients coming for surgery/procedure, however, recent audit highlighted lack of quality in performance of WHO Safer Surgery Checklist.	**MED 6 21/09/2013**	**EXTREME 16** ⇔	**LOW 1**	For discussion at divisional Board/QUASH day Surgical specialty compliance to be added to the theatre dashboard	**March 2014** – Overall improvement achieved in March, ASH 98.78% & SPH 94.58%. On-going individual monitoring	01/05/2014	Executive Lead: Suzanne Rankin Lead Manager Sue Sexton
967	LSCS rate - Non compliant with CCG target	LSCS rate running 2-3% above CCG target of 23.6%.	**HIGH 03/09/2009**	**EXTREME 16** ⇔	**LOW 1**	Action plan to be developed for CCG to avoid a fine for the Trust. Specific piece of work around the antenatal intra partum pathway which will be a practice based review with recommendations for improvement opportunities.	**March 2014** -outcome of the External Cephalic Version (ECV) audit is still awaited. The current rate is YTD 26.3%. Once the ECV audit has been completed there will be a further action plan. An external review of the antenatal care pathway is currently being undertaken which may also reveal work that may impact upon the caesarean section rate. The report is expected May/June 2014.	01/05/2014	Executive Lead: Paul Crawshaw Lead Manager Jacqui Rees

Risks Downgraded

ID	Title	Description	Risk Opened	Risk level (current)	Risk Level Target	Action Plan	**Progress**	Review date	Monitoring
1296	Backlog of typing clinical letters and result filing in the clinical offices in General Surgery	The backlog of typing letters and filing of the results is widespread in general surgery however, it is more prevalent in colorectal, upper GI and Breast specialties.	**EXTREME** 16 ⇔	**HIGH 9** ↓	**LOW 1**	Recruit and place additional admin support to clear backlog, Review and prioritise the outstanding work Review volumes vs. WTE per clinical office Weekly monitoring	**March 2014 –** Of the 5 vacant posts, 3 were for general surgery and these have now been recruited to. Further interviews are scheduled for the 18th April to recruit two further	01/05/2014	Executive Lead John Hadley Manager Lead: Victoria Griffiths

						Manage staffing issues i.e. sickness	"floating" admin posts to support Upper GI, Vascular and Colorectal. It is expected this will greatly improve the situation in terms of a manageable backlog. **Risk reduced to high level 9**		
1312	Absence of one stop clinics in urology	Absence of one stop clinics in urology, causing delays in patients being put on the cancer and 18 weeks pathway as this requires multiple appointments. There are a significant amount of cancer breaches per month in urology which impacts on the overall Trust performance. Cancer peer review The last two cancer peer has raised the absence of one stop clinics as a concern.	**EXTREME 16** 	**HIGH 9** 	**LOW 1**	To explore and establish if the Urology Services can be centralised on one site? To explore other ways of achieving the one stop clinics while waiting for centralising services on one site This will be monitored regularly and the risk level will be changed according to the findings	**March 2014** – One Stop Clinics to be renamed Rapid Access Diagnostic Services following Clinical Urology Summit in March. Action plan to be developed and Pathway Event to be organised. **Risk reduced to high level 9**	01/05/2014	Executive Lead John Hadley Manager Lead: Victoria Griffiths
1336	Concern relating to temporary staffing shortage and full provision of governance service in TASCC	1. 8a and 8b recruited to vacant posts planned to commence work April 14. 2. Following quality restructure governance posts have remained vacant since Nov 13. 3. Governance post identified in January 13 - unable to recruit to due to quality restructure. 4. Unable to recruit 2 x interim personnel.	**EXTREME 16** 	**MED 6** 	**LOW 1**	1. Band 6 post requires redefining and recruiting to, currently out to advert	**April 2014** – Head of Patient Experience and Quality Governance Manager now started in Trust, still to recruit band 6, risk therefore reduced to a **medium level 6** **Feb 2014 New Trust Risk** Risk raised following discussion at the Risk & Scrutiny Committee on 5th February 2014.	01/06/2014	Executive Lead: Suzanne Rankin Lead Manager: Sue Sexton