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

TRUST BOARD
24th February 2011

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 9th February 2011, and highlights: • **Three New Risks** added since 2nd December 2010 • Four existing risks where the risk level has changed since 2nd December 2010 • Two risks with a changed treatment plan since 2nd Dec 2010 • Zero risks closed since 2nd December 2010. This report now includes a Target Risk Score should all the mitigating actions be successfully achieved.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Corporate Risk Register report provides assurance that relevant risks have been identified as corporate risks and that mitigating actions are in place. The report contains summary information, the full Corporate Risk Register, as well as details of those risks closed in the period.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	The Corporate 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 review the contents of the Corporate Risk Register in order to assure itself that all risks are accurately identified and mitigated adequately.
Submitted by:	Marty Williams, Clinical Risk Manager on behalf of, Suzanne Rankin, Chief Nurse
Date:	24th February 2011
Decision:	For noting.

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

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Corporate Risk Register

Process

All risks submitted for inclusion within the Corporate Register must have a completed Trust Risk Register Notification Form. In the first instance the Manager of the area where the risk has been identified is to discuss the risk with the appropriate Lead Executive Director.

If, in the view of the Lead Executive Director, the Trust Risk Register Notification Form contains all relevant information and is an appropriate entry for the Corporate Risk Register the risk will be entered onto the Corporate Risk Register.

On a monthly basis, at the Trust Executive Committee meetings, all new risks entered on the Corporate Risk Register will be highlighted and discussed. The Corporate Risk Register last went to the Trust Executive Committee meeting on 28th January 2011. The next meeting is 25th February 2011

New Risks added since 2nd December 2010

ID	Title	Description	Present Objective	Risk level	Responsibility Owners
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	The NPSA issued a safer practice notice to highlight issues related to early identification of failure to act on radiological imaging reports. The deadline for closure of this alert was February 2008. In summary patient safety incidents are being caused by a failure to acknowledge and act on radiological imaging reports. Radiology imaging tests are requested by a registered health professional that relies on a report and image usually generated by a radiologist or radiographer. The report and image are sent to the referring health professional, who then acts on the result. The system for requesting radiology imaging tests and sending reports to the referring health professional is unreliable and has been proven to fail. The Trust has had several cases of missed diagnosis related to this issue and most recently an SUI. Despite ongoing work to address this, the Trust has not been able to resolve the issues. Risk patients and Trust reputation.	TREAT	HIGH	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.
1113	Fraud and Corruption	The financial loss risk of the misuse or misappropriation of public funds. This risk arose from an external audit from KMPG and then was discussed at ,and agreed, by the Audit Committee to be placed on the Corporate Risk Register	TREAT	HIGH	Executive Director: John Headley Lead Manager: Miriam Moore

1110	Loss of NHS income arising from damage to property.	The Trust is a member of the Property Expenses Scheme (PES) with the NHS Litigation Authority (NHSLA) which provides insurance cover for business interruption expenses arising from an accepted property damage claim with a limit of up to £1m. In addition to this the Trust has purchased top-up insurance to increase cover to £10m. However, whilst this insurance covers increased cost of working arising from all activities, it only covers loss of gross profit from income generation activities, leaving the Trust exposed should it suffer loss of NHS income as a result of damage to property.	TOL	HIGH	Executive Director: John Headley Lead Manager: Miriam Moore

Existing Risks where the risk level has changed since 2nd December 2010

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
768	Staff recruitment and retention. (BAF 2.2)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff resulting in a risk of inadequate staffing with a consequent impact on the quality of patient care.	*Previous progress held on paper in the Quality Department - R R section.* **Feb 11: 1. Sustained downward trend in nurse vacancies (qualified vacancies down from 16.2% in April to 10.3% in December. Net qualified Nurse & Midwife headcount has increased by 45 since April. 13 new Band 5 staff nurses being processed for medical wards plus 14 for other areas. 2. ONP course commenced in September. 18 nurses on track to register with NMC in Feb and transfer into band 5 posts. 3. 1 A&E Consultant to commence 14 March 2011. Bank Consultant started February 2011. Further advertisements for Consultant and middle grade positions open - interviews 5th March 2011. Enhanced bank rates agreed until end of March to mitigate agency expenditure. Risk reduced to medium.**	HIGH	MED	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber

1089	Lack of outpatients receptionist staff in the Trust.	This is a Risk to: compliance with PbyR and RTT data quality standards, the Trust's reputation as a result of a poor outcome of Picker Outpatient Survey Report, increased staff sickness levels, continued reliance on Bank and Agency staff. Current established staffing is at a ratio of 250-290 patients per receptionist (depending on site and week day). In addition, no uplift is in place to allow for sickness or annual leave, leaving remaining staff carrying an additional burden of patients to process through outpatient reception. Recommended staffing ratios should be around 70-100 patients per receptionist. More detail is shown in the original paper copy of the Notification Form.	Nov 10: Sickness Capability Policy being implemented **Feb 11: Action plan improved (please see above). Risk score now reduced from High to Medium as a result of action plan.**	HIGH	MED	Executive Director: Valerie Bartlett Lead manager: Hannah Donoghue (Patient Access)
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	*Previous progress held on paper by the Quality Department - R R section.* Nov 10: Instigation of CIP sign off meetings at Month close. Development of risks and opportunities schedule. Risk score lowered from 12 to 8 but remains a high risk. **Feb 11: Risk of major failure of CIP programme for 2010/2011 now reduced to Medium and Tolerated**	HIGH	MED	Executive Director: John Headley Lead Manager: Rob Jeffries
1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	The impact means that The Trust's ability to maintain capacity flow, 4 hour waits & 18 week targets are very much reduced. The NHS Funded healthcare team have been asked by Claire O'Brien whether they would be prepared to second one of their nurse assessors to work at ASPH for 6 months to assist the Senior Discharge Co-coordinator to train ward staff to undertake some of the assessments. The NHS funded Healthcare team has confirmed it is not possible to release one of their nurse assessors as they have a back log of assessments to carry out in the community and do not have sufficient staff to support this.Risk to patients, service, finances, not meeting targets and Trust reputation.	Oct 10: Current discharge team have managed to get through current back-log however demand continues; additional bank resource and recruitment of new staff to discharge team will support management of demand. Risk reduced from High to Medium and Tolerated. (Claire O'Brien) **Jan 11: Await confirmation for additional resource. There will be an on-going back log until staff are recruited and appropriately trained. Risk returned to High and Treat.**	MED	HIGH	Executive Director: Valerie Bartlett Lead Manager: Claire O'Brien cc Juliet Rayner

Risk with a changed treatment plan since 2nd December 2010

847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	*Previous progress held on paper by the Quality Department - R R section.* Nov 10: Instigation of CIP sign off meetings at Month close. Development of risks and opportunities schedule. Risk score lowered from 12 to 8 but remains a high risk. **Feb 11: Risk of major failure of CIP programme for 2010/2011 now reduced to Medium and Tolerated**	HIGH	MED	Executive Director: John Headley Lead Manager: Rob Jeffries
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Risk closed since 2nd December 2010

None

Summary of Corporate Risks as at 9th February 2011

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risks							
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	HIGH	12	TREAT	12-Mar-2008	2-Mar-2011	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	HIGH	12	TREAT	12-Mar-2008	2-Apr-2011	Executive Director: Valerie Bartlett (Howell) Lead Manager: Valerie Bartlett (Howell)
1024	Loss of income due to application of 'non elective cap'	HIGH	12	TREAT	23-Jun-2010	2-Feb-2011	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
1088	Possible non-compliance with IG Toolkit submission and achievement of Level 2 on all requirements	HIGH	12	TREAT	12-Oct-2010	2-Mar-2011	Executive Director: John Headley Lead manager: Tracy Street
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	HIGH	12	TREAT	2-Feb-2011	2-Apr-2011	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.
1113	Fraud and Corruption	HIGH	10	TREAT	2-Feb-2011	2-Apr-2011	Executive Director: John Headley Lead Manager: Miriam Moore
1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	HIGH	9	TREAT	31-Aug-2010	2-Mar-2011	Executive Director: Valerie Bartlett Lead Manager: Claire O'Brien cc Juliet Rayner
1072	Discharge process has identified risks to vulnerable patients	HIGH	9	TREAT	2-Sep-2010	3-Mar-2011	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis cc Claire O'Brien
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	HIGH	9	TREAT	27-Oct-2008	2-Apr-2011	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
832	Loss of income-Contracts. (BAF 3.4)	HIGH	8	TREAT	26-Mar-2009	2-Mar-2011	Executive Director: John Headley Lead Manager: Sue Robertson
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	2-May-2011	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	2-Apr-2011	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	8-Mar-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down
1083	Corporate lack of Trust Social Services worker post	MED	6	TREAT	21-Sep-2010	2-Apr-2011	Executive Director: Suzanne Rankin Contact: Michael Hooker
1089	Lack of outpatients receptionist staff in the Trust.	MED	6	TREAT	12-Oct-2010	2-May-2011	Executive Director: Valerie Howell Lead manager: Hannah Donoghue

Summary of Corporate Risks as at 9th February 2011

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
837	Delay in Psychiatric assessment - A & E and MAU	MED	6	TREAT	9-Apr-2009	2-Mar-2011	Executive Director: ValerieBartlett Lead Manager: Laura Stanard
768	Staff recruitment and retention. (BAF 2.2)	MED	6	TREAT	12-Mar-2008	2-May-2011	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber
769	Disproportionate focus on post Foundation Trust authorisation tasks.	MED	4	TREAT	12-Mar-2008	5-Mar-2011	Executive Director: Raj Bhamber Lead Manager: Raj Bhamber, Vicki Hart-Dale
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	2-May-2011	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1.8)	LOW	3	TREAT	12-Mar-2008	2-May-2011	Executive Directors: Suzanne Rankin Lead Manager: Vanessa Avlonitis
988	VTE phrophylaxsis assessment shortfall	LOW	2	TREAT	25-Feb-2010	5-Mar-2011	Executive Director: Mike Baxter Lead Manager: Mike Baxter
Tolerate: Accept the risk at its current level of risk							
1110	Loss of NHS income arising from damage to property.	HIGH	8	TOL	20-Jan-2011	11-Mar-2011	Executive Director: John Headley Lead Manager: Miriam Moore
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	MED	4	TOL	20-May-2009	2-Jun-2011	Executive Director: John Headley Lead Manager: Rob Jeffries

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk											
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions. risk to patients and Trust reputation	12	HIGH	12-Mar-2008	2-Mar-2011	All previous action plans can be accessed from paperwork held in the Quality department. Aug 10: Trust wide MRSA action plan updated 9th August and local blood culture action plan formulated following the five MRSA bacteraemias Root Cause Analysis. Details held with paper copy update. **Jan 11: Action Plan updated December 2010. to reflect that all the actions remain ongoing**	*Previous updates can be accessed from paperwork held in the Quality department.* Nov 10: No MRSA bacteraemia since 29th July 10. Likelihood reduced to 3 resulting in a risk level of High from the previous Extreme. **Jan 11: No MRSA bacteraemia since 29th July 2010 The instigation of the dedicated blood culture taking service has been very successful. Aseptic technique competencies continues to be rolled out Trustwide for healthcare staff.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	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.	12	HIGH	12-Mar-2008	2-Apr-2011	*Previous Action Plans held on paper in Quality -RR section* Dec 10: Increased focus on all aspects of patient flow, discharge and management of the front door to ensure good and safe flow of patients through the system and to maintain key operational targets, particularly A and E four hour wait. **Feb 11:Action plan being amended to provide additional lists as needed to meet 18 weeks**.	*Previous progress held on paper by the Quality Department - R R section* **Feb 11:For 2010/11 both 90% and 4 hr standard should be achieved. The challenge is to balance elective activity against emergency demand, work is underway to validate elective activity booked and ensure lists are managed so that this target is achieved, this will require significant attention and extra activity to be booked between now and the end of March. The specialties concerned are Surgery and Ophthalmology. ASPH will achieve the 95% 4 hour standard as required by Monitor when all 4 hour performances are aggregated. For both targets forensic attention to detail will be required to ensure there is not slippage.**	4	MED	Executive Director: Valerie Bartlett (Howell) Lead Manager: Valerie Bartlett (Howell)

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1024	Loss of income due to application of 'non elective cap'	Under the standard 2010/11 PCT contracts, the value of emergency admissions over a 2008/9 threshold is reimbursed at a 30% marginal rate. Growth in non elective admissions will generate more costs than income and may prevent the Trust meeting its financial targets	12	HIGH	23-Jun-2010	2-Feb-2011	Action plans are in place to manage non elective admissions. These are being overseen by Programme 2 'Improving service productivity and quality' Dec 10: Action plan being reviewed and updated as we monitor the impact of Winter on our performance. Refer to progress for the latest aspects of this.	Previous progress held on paper in the Quality dept. Dec 10: Changes underway in A and E and Specialist Assessment Pathways. Implementing attendance avoidance pilot and further work underway for Ambulatory Care Pathways. **Feb 11: 1.Wider engagement with Primary community partners through NW Transformation Board Project group 1 resulting in stronger support for implementation of ambulatory care pathways.** **2. Meet and Greet pilot in A&E to support redirection of patients to alternatives to A&E due to start Feb 2011.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
1088	Possible non-compliance with IG Toolkit submission and achievement of Level 2 on all requirements	Version 8 of the toolkit states that all requirements now need to be scored at Level 2 or higher in order for the assessment to be satisfactory. Failure of any one requirement will result in an unsatisfactory result and could impact on the SOC held by the Trust. Particular concern is around the requirement of IG training and that 95% of all staff have to complete the online training. Risk of financial loss, failure to meet National targets and statutory duty.	12	HIGH	12-Oct-2010	2-Mar-2011	Action plan currently being drawn up by IG manager in order to identify gaps and to nominate leads on each requirement Nov 10: Awareness sessions to be run where requested by departments Briefing paper to be prepared for all staff on mandatory IG training. **Jan 11: IG Manager and IT Trainers working together to assist staff in completing the online training.** **Particular work being carried out with staff where English is not their first language in order to benchmark results.**	Nov 10: Staff briefing paper being developed by the IG manager. **Jan 11: There has been a increase in compliance with a total of 799 staff members having completed this training.**	3	LOW	Executive Director: John Headley Lead manager: Tracy Street

Corporate Risk Register as at 9th February 2011

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1112	Failure to act on radiological imaging reports resulting in missed diagnosis	The NPSA issued a safer practice notice to highlight issues related to early identification of failure to act on radiological imaging reports. The deadline for closure of this alert was February 2008. In summary patient safety incidents are being caused by a failure to acknowledge and act on radiological imaging reports. Radiology imaging tests are requested by a registered health professional that relies on a report and image usually generated by a radiologist or radiographer. The report and image are sent to the referring health professional, who then acts on the result. The system for requesting radiology imaging tests and sending reports to the referring health professional is unreliable and has been proven to fail. The Trust has had several cases of missed diagnosis related to this issue and most recently an SUI. Despite ongoing work to address this, the Trust has not been able to resolve the issues. Risk patients and Trust reputation.	12	HIGH	2-Feb-2011	2-Apr-2011	1. For inpatients, the printed Code 5 priority reports from x ray should be sent not only to the ward but also directly to the consultant identified as the requesting physician at the time of request 2. Before junior Drs are allowed to order CT scans they must discuss and get approval from the on call consultant 3. The radiology department should not accept requests stating "consultant unknown" and it should be the responsibility of the requesting doctor to complete this field. If possible "consultant unknown" should be removed as an option 4. A pilot of CRIS software "Communicator" package is underway whereby the referring clinician may be notified either by text, e mail or bleep of an urgent result that they should review. If this is successful consideration should be given to extending the use of this process to inform consultant staff directly of any code 5 report issued on inpatients under their care. A process should be developed so that receipt is formally acknowledged. More on Notification Form		3	LOW	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.

Corporate Risk Register as at 9th February 2011

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1113	Fraud and Corruption	The financial loss risk of the misuse or misappropriation of public funds. This risk arose from an external audit from KMPG and then was discussed at ,and agreed, by the Audit Committee to be placed on the Corporate Risk Register	10	HIGH	2-Feb-2011	2-Apr-2011	1. The Trust engages a Local Counter Fraud Specialist (LCFS) to assess the level of fraud and corruption the Trust faces. There is an annual work plan in place for the LCFS which is determined in conjunction with the Head of Internal Audit and the Director of Finance and is approved by the Audit Committee. LCFS work is undertaken with the additional guidance and oversight of the NHS Counter Fraud and Security Management Service. 2. All new staff attend an induction programme which includes a fraud awareness session lead by the LCFS. There is a Fraud Management Policy and a Whistle-blowing Policy in place at the Trust and both policies can be accessed by staff on the Trust's Intranet. There is a quarterly e-newsletter for staff on this risk plus case studies in Aspire. Proactive exercises to test for this risk are also undertaken by the LCFS in vital or high- risk areas.		3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 9th February 2011

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1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	The impact of delayed discharges means that The Trust's ability to maintain capacity flow, 4 hour waits & 18 week targets are very much reduced. The NHS Funded healthcare team have been asked by Claire O'Brien whether they would be prepared to second one of their nurse assessors to work at ASPH for 6 months to assist the Senior Discharge Co-coordinator to train ward staff to undertake some of the assessments. The NHS funded Healthcare team has confirmed it is not possible to release one of their nurse assessors as they have a back log of assessments to carry out in the community and do not have sufficient staff to support this. Risk to patients, service, finances, not meeting targets and Trust reputation.	9	HIGH	31-Aug-2010	2-Mar-2011	*Previous Action Plans held on paper in Quality -RR section* Oct 10: Plan to use RN 4 days per week to support MDT training for NHS funded care checklists and Decision Support tool (DST) assessments. **Jan 11 : Interim senior nurse working with discharge team to support outstanding assessment and weekend working planned to reduce back log. Long term plan to increase discharge team to support wards with complex case management**	Oct 10: Current discharge team have managed to get through current back-log however demand continues; additional bank resource and recruitment of new staff to discharge team will support management of demand. Risk reduced from High to Medium and Tolerated. (Claire O'Brien) **Jan 11: Await confirmation for additional resource. There will be an on-going back log until staff are recruited and appropriately trained. Risk returned to High and Treat.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Claire O'Brien cc Juliet Rayner

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1072	Discharge process has identified risks to vulnerable patients	Cause for concerns relating to poor discharge planning Discharge themes identified through complaints and PALS analysis	9	HIGH	2-Sep-2010	3-Mar-2011	1. Review Discharge Policy 2. Multidisciplinary team meetings to expedite discharge plans. 3. Estimated date of discharge to be agreed and adjusted according to patients medical, functional and cognitive needs. 4. Development of a seamless patient pathway for elderly complex discharges 5. Develop training for ward sisters 6. Communication , using the daily white boards, auditing of the use of the discharge check list 7. More responsive nurse handover promoting nurses handover at the bedside 8. Maintain continuity of care by Medical staff 9. Managing expectations of family and carers working in partnership. 10. End of Life Care pathway 11. Discharge prior to holiday period 12. Winterplanning and capacity 13. Readmissions identified	Nov 10:Project team set up and actions in progress, risk matrix in development. Inputting to Sisters meetings and part of the planned Sister development programme. Nursing workforce review in consultation to strengthen the Divisional Nursing structure. EDD against actual and gap analysis is being discussed. New nursing documentation of the SAP launch 22nd November. **Jan 11: Project team in place and PID developed. and actions in progress, risk matrix in development. Inputting to Sisters meetings and part of the planned Sister development programme. This is starting in January 2011. Nursing workforce review completed to strengthen the Divisional Nursing structure. EDD against actual and gap analysis is in place. New nursing documentation pilot complete and live by February. End of Life pilot for the Nursing home satellite residences to prevent admission to hospital.**	3	LOW	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis cc Claire O'Brien
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	The Trust policy database has only 13% of its policies in date. (October 08) Risk to patients, staff and service. Risk of not meeting the requirements of NHSLA risk management standards.	9	HIGH	27-Oct-2008	2-Apr-2011	*Previous action plans held on paper by the Quality department - R R section.* **Feb 11: In discussion with CCG, the Heads of Service will be provided with a list of all policies and take responsibility for those within their team. Reminders will be sent. The Quality department will link with Heads of Service for performance management and policy owners for support. Nursing action plan timescale are being reviewed.**	*Previous updates held on paper in the Quality department - R R section.* **Feb 11: 60% of policies are in date. The nursing action plan requires review of timescales to provide a robust plan to up date the policies that can be delivered. Other out of date policies have been fed back to the Heads of Service for action. Severity reduced to 3 but risk remains high.**	4	MED	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
832	Loss of income-Contracts. (BAF 3.4)	There is a loss of income related to DH-mandated financial penalties, for non-achievement of key performance targets, including single-sex accomodation	8	HIGH	26-Mar-2009	2-Mar-2011	*Previous Action Plan/s held on paper in the Quality department - Risk Register section.* Nov 10: Report being developed with Information dept to assist Divisions in auditing any potential LPP activity. **Jan 11: Action Plan as before plus additional work on AD Operations and Deputy Chief Nurse to assure compliance with single sex accomodation requirements.**	*All previous progress held on paper in the Quality department - Risk Register section.* Nov 10: Reporting on CQUIN to Board via Finance report. Clinical Divisions still finalising the format of their monthly dashboards, but CQUIN information already available at Divisional level and shared with GMs. **Jan 11: Year end financial deal being agreed with NHS Surrey provides assurance in relation to income including CQUIN.**	6	MED	Executive Director: John Headley Lead Manager: Sue Robertson
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers namely Alliance and Inhealth.	6	MED	26-Mar-2009	2-May-2011	1. Re-negotiation of contract for a 10 year period with Alliance. 2. Negotiate a contract extension for 18 months with Inhealth. 3. Joint management boards to review quarterly.	*All previous progress held on paper by the Quality Department - R R section.* Dec 10: Undergoing a review of the action plan and progress with new lead manager (KL). **Feb 11: Private service provided by InHealth put out to tender January 2011. Timescales fall within plan to ensure continuity of service and manage risk of loss of provider.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
1037	Failure to monitor and review compliance with CQC regulations.	New documentation from CQC is ongoing as CQC establish approach and changes may occur due to new government. Compliance with regulations is prospective and the Trust must develop an approach which demonstrates we are able to identify and respond to gaps quickly, with a focus on delivery of outcomes as well as process.	6	MED	16-Jul-2010	2-Apr-2011	*Previous Action Plan/s held on paper in the Quality department - R R section.* Oct 10: Link in with committees to good understanding of requirements to oversee relevant outcomes. **Jan 11: Process to be reviewed with new Chief Nurse to consider if the process needs to change to fit in with the new divisional approach.**	*All previous progress held on paper by the Quality Department - R R section.* Oct 10: QRP (risk rating) from CQC received with no red risk areas. Ongoing monitoring of standards in place. Risk reduced from High to Medium. **Jan 11: Review of standards continues under current process , gaps being identified, QRP process in place, to keep risk in place for review by IGAC in February and April to ensure embedding of current process. Committees approach needs to be evidenced to provide assurance of action against CQC.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1057	Possible loss of patient confidence in the Complaints service.	The Trust is working to devolve responsibility for the drafting of complaint responses to Divisions. Complaints management is governed by Legislation, CQC and NHSLA standards. Also monitored by PHSO. There is a need to adhere to governance standards and continue to maintain high standards in complaints management while ensuring a high quality response. Risk to Trust reputation and failure of statutory duty	6	MED	12-Aug-2010	8-Mar-2011	1. Resource library on T drive including guidance notes and 'top tips'. 2. Clarity of expectation and performance standards with associated monitoring (via Customer Affairs and Performance meetings). 3. Training with Directorates as required. 4. Continued process of qualitative assurance. (Complaints Manger, Head of Customer Affairs, Chief Nurse). 5. Complaints Office support within Divisions. 6. Ongoing discussion with General Managers re implementation. **Nov 10: Review at the next CMG meeting in February 2010.**	**Nov 10: The risk and action plan were fully discussed at the Complaints Monitoring Group on 5 Nov where it was agreed the risk remain unchanged. The action plan will be monitored and reviewed at the next meeting on 4 February 2011.**	3		Executive Director: Suzanne Rankin Lead Manager: Jill Down
1083	Corporate lack of Trust Social Services worker post	Currently there is no designated social services worker to lead on safeguarding children by the local authority. The risk is that vulnerable children could be missed or become unsupported by the lack of continuity of a designated social worker identified for the Trust. This risk applies to wherever children are cared for within the Trust, specifically Paediatric A&E, Paediatric wards and Paediatric Outpatients. Risk to patients, service, reputation and failure of statutory duty.	6	MED	21-Sep-2010	2-Apr-2011	The risk has been on the Children's Services Risk Register since December 2009. Since which time steps have been taken, including the naming of a link social worker and updating of processes in A&E, however the risk still persists. Following escalation, our Chief Executive wrote to the Chief Executive of Surrey County Council to arrange a meeting. Since which time our Chief Executive has spoken on the telephone with Andy Roberts, Strategic Director for Children, Schools and Families who has agreed to do a fast review of the situation.	Nov 10: Mitigation arrangements put in place including strengthening of link Social services worker, now confirmed as from Assessment Team. Strategy meetings to take place on SPH site where child is an inpatient. Ongoing monitoring of the situation ie low threshold for reporting of adverse incident which occur as a result of the lack of SW. Risk reduced from High to Medium (MH) **Jan 11: Continue ongoing monitoring of the situation ie low threshold for reporting of adverse incident which occur as a result of the lack of SW**	3	LOW	Executive Director: Suzanne Rankin Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby Contact: Michael Hooker

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1089	Lack of outpatients receptionist staff in the Trust.	This is a Risk to: compliance with PbyR and RTT data quality standards, the Trust's reputation as a result of a poor outcome of Picker Outpatient Survey Report, increased staff sickness levels, continued reliance on Bank and Agency staff. Current established staffing is at a ratio of 250-290 patients per receptionist (depending on site and week day). In addition, no uplift is in place to allow for sickness or annual leave, leaving remaining staff carrying an additional burden of patients to process through outpatient reception. Recommended staffing ratios should be around 70-100 patients per receptionist. More detail is shown in the original paper copy of the Notification Form.	6	MED	12-Oct-2010	2-May-2011	A Business Case is to be submitted to provide adequate staffing levels. *Previous Action Plans held on paper in the Quality Department.* **Feb 11: Outpatient Efficiency Workstream being led by B Jones - will identify efficiencies to outpatient flow and areas for improvement to free up existing staff. Whilst workstream in progress, minimal agency/Bank being used to cover on ad-hoc basis. Merge of Front of House Reception and Outpatient Reception now completed - training of FoH staff being undertaken to ensure cross cover is available. Electronic self-check-in service to free up Reception staff will form part of efficiency workstream. 2 vacancies will be back filled with staff working on a flexible basis across both sites to enable greater flexibility. Existing staff now trained to enable them to flex across different sites and specialties.**	Nov 10: Sickness Capability Policy being operated. **Feb 11: Action plan improved (please see left). Risk score now reduced to Medium as a result of action plan.**	3	LOW	Executive Director: Valerie Howell Lead manager: Hannah Donoghue (Patient Access)

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
837	Delay in Psychiatric assessment - A & E and MAU	Due to a change in the service the home treatment team (HTT) provide assessment of psychiatric referrals in A & E. The current service has been placed at a lower priority . There is restricted out of hours service. This results in delays in acute psychiatric assessments. At risk: Patients, staff and service. (4hr target)	6	MED	9-Apr-2009	2-Mar-2011	**Previous Action Plans held on paper in the Quality Department.** Aug 10: 1. Develop one-page overview of which psychiatric services to contact under what circumstances - Nasreen Moosafur, 31 August (Lead, Liaison Psychiatric Team) 2. Write-up issues arising related to psychiatric patients in the A&E and email to Lucy O'Meara - A&E, ongoing (6+ forms have submitted to date) 3. Implement monthly Local Mental Health Interface meetings - N Moosafur, K Lawrence, W Daniels (complete - first meeting scheduled for 9 September) 4. Increase the number of psychiatric nurses as part of the Liaison Psychiatry team from 1 to 3 and increase cover from 5 pm up until 8 pm - Lucy O'Meara, 31 July (delayed due to consultation process) 5. Consider commissioning of 3 PAs per week of Consultant Psychiatric time - Claire O'Brien/Pat Rubin 6. Develop joint care plans for top re-attenders to A&E - Nasreen Moosafur & Wendy Daniels, 30 Sept and ongoing 7. Develop a joint agenda for improving care of patients presenting at A&E with psychiatric issues - N Moosafur, W Daniels	*All previous updates held on paper by the Quality department - Risk Register section* **Nov 10: Monthly Interface meetings now in place - Kate Lawrence's name to be replaced by Charlotte Freeman. Claire O'Brien has commissioned additional psychiatric assessments of Consultant time from 1st Dec. Additional meeting to be held with A&E and Brian Parsons to agree way forward on 17th November.**	2	LOW	Executive Director: Valerie Bartlett Lead Manager: Laura Stanard Contact: Laura Stannard

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
768	Staff recruitment and retention. (BAF 2.2)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff resulting in a risk of inadequate staffing with a consequent impact on the quality of patient care.	6	MED	12-Mar-2008	2-May-2011	Previous Action Plans held on paper in the Quality Department - R R section. Feb 11: (update of Dec 10 plan) - 1. Continued implementation of Nursing R&R Strategy/action plan includes rolling, generic recruitment for band 5 nurses. 2. Continuation of ONP course, ending in February (18 participants). 3. Implementation of nursing workforce review to inform future recruitment plans 4. Recruitment of A&E doctors & implementation of new middle grade A&E rota. 5. Reduction in Midwifery vacancy rate since August continues to be supported through dedicated action plan which has resulted in all current vacancies being filled through actual and prospective new starters	*Previous progress held on paper in the Quality Department - R R section.* **Feb 11: 1. Sustained downward trend in nurse vacancies (qualified vacancies down from 16.2% in April to 10.3% in December. Net qualified Nurse & Midwife headcount has increased by 45 since April. 13 new Band 5 staff nurses being processed for medical wards plus 14 for other areas.** **2. ONP course commenced in September. 18 nurses on track to register with NMC in Feb and transfer into band 5 posts.** **3. 1 A&E Consultant to commence 14 March 2011. Bank Consultant started February 2011. Further advertisements for Consultant and middle grade positions open - interviews 5th March 2011. Enhanced bank rates agreed until end of March to mitigate agency expenditure. Risk reduced to medium.**	4	MED	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber
769	Disproportionate focus on post Foundation Trust authorisation tasks.	The Foundation Trust application has significant potential to divert Executive and Clinical Directors from achieving our ASPH organisational objectives.	4	MED	12-Mar-2008	5-Mar-2011	*Previous Action Plan/s held on paper by the Quality Department - R R section.* July 10: The Foundation Trust application (strategic objectives in the IBP) & Corporate Plan (annual objectives) are aligned. A dedicated Project Manager is coordinating the FTA through the FT Board. Sep 10: No change to the action plan	*Previous progress held on paper by the Quality Department - Risk Register section.* **Nov 10: The risk has changed to 'Disproportionate focus on post FT authorisation tasks'. The risk will be managed by identified resources in the dedicated membership office and the Communications Team to plan and implement post authorisation tasks.**	3	LOW	Executive Director: Raj Bhamber Lead Manager: Raj Bhamber, Vicki Hart-Dale

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
766	Patient satisfaction scores. (BAF 1.7)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	4	MED	12-Mar-2008	2-May-2011	*Previous Action Plan/s held on paper by the Quality Department - R R section.* **Dec 10: 1. Patient information subgroup formed** **2. Patient Access subgroup formed** **3. Identify top three trends from 'your' feedback** **4. Triangulating data from 'Your' Feedback** **5. Discharge planning group with matrix.** **6. Focus on End of Life Care.** **7. Incentivisation of staff.** **8. Relaunch the Patient Experience indicators.**	All previous progress held on paper by the Quality Department - R R section. Sep 10: Dignity gowns are now being trialled. Ward Quality indicators are in place. Noise at night has progressed but remains an issue for some patients. The patient comment card is providing weekly feedback. **Dec 10: This is work in progress and will be monitored through the Programme Board.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1.8)	Potential failure to improve upon Privacy and Dignity issues for service users resulting in possible patient anxiety and risk to Trust reputation	3	LOW	12-Mar-2008	2-May-2011	*Previous Action Plan/s held on paper by the Quality Department - R R section .* **Nov 10: Needs to be kept on the risk register due to capacity pressures although currently compliant and refurbishment almost complete.**	*Previous progress held on paper in the Quality Department - R R section* **Nov 2010: No change except that Kestral has opened. Plans to address Privacy and Dignity for the older person in January 2011.**	2	LOW	Executive Directors: Suzanne Rankin Lead Manager: Vanessa Avlonitis
988	VTE prophylaxis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently (25/02/10) the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	2	LOW	25-Feb-2010	5-Mar-2011	*Previous Action Plan/s held on paper by the Quality Department - R R section.* June 10: 1. VTE monitoring to be performed weekly, to supply national and CQUIN information. 2. VTE compliance is to be on all directorate performance dashboards and reviewed at monthly performance meetings.	*Previous progress held on paper in the Quality Department - R R section.* **Nov 10: Trust now compliant at 90%. SHA has identified ASPH as an exemplar site. RCA for all admissions with PE and DUT now in place. Monthly audits of VTE assessment quality with PE and DUT now in place. Monthly audits of VTE assessment quality to be commenced December 2010. Risk reduced from medium to low.**	2	LOW	Executive Director: Mike Baxter Lead Manager: Mike Baxter

Corporate Risk Register as at 9th February 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
Tolerate: Accept the risk at its current level of risk.											
1110	Loss of NHS income arising from damage to property.	The Trust is a member of the Property Expenses Scheme (PES) with the NHS Litigation Authority (NHSLA) which provides insurance cover for business interruption expenses arising from an accepted property damage claim with a limit of up to £1m. In addition to this the Trust has purchased top-up insurance to increase cover to £10m. However, whilst this insurance covers increased cost of working arising from all activities, it only covers loss of gross profit from income generation activities, leaving the Trust exposed should it suffer loss of NHS income as a result of damage to property.	8	HIGH	20-Jan-2011	11-Mar-2011	The risk could be reduced by purchasing insurance cover but this is costly and the Board has decided not to purchase cover for loss of NHS income at this stage. In reaching this decision the Board noted one mitigation against the risk was that the Trust operated from two discrete sites. The Trust has Business Continuity Plans (including Disaster Plans) in place that should help mitigate the amount of down time that would lead to such a loss of NHS income.		2	LOW	Executive Director: John Headley Lead Manager: Miriam Moore
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	4	MED	20-May-2009	2-Jun-2011	*Previous Action Plan/s held on paper by the Quality Department - R R section.* Aug 10: Revaluation of all existing schemes. Increased governance arrangements around all schemes. Weekly update to CEO. Weekly update on schemes progress by General Managers. Re-launch of CIP programme. Additional schemes identified.	*Previous progress held on paper by the Quality Department - R R section .* Nov 10: Instigation of CIP sign off meetings at Month close. Development of risks and opportunities schedule. Risk score lowered from 12 to 8 but remains a high risk. **Feb 11: Risk of major failure of CIP programme for 2010/2011 now reduced to Medium and Tolerated**	2	LOW	Executive Director: John Headley Lead Manager: Rob Jeffries