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

TRUST BOARD
26th January 2012

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 18th January 2012, and highlights that since 19th October 2011: • One risk was opened and subsequently closed • Three risks have an increased risk score • Two risks have a reduced risk score 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 to note 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, Head of Patient Safety On behalf of, Suzanne Rankin, Chief Nurse
Date:	18th January 2012
Decision:	For Review

Ashford and St. Peter's Hospitals NHS
NHS Trust

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Corporate Risk Register

Process

All risks submitted for inclusion on 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 16th December 2011. The next meeting is 27th January 2012.

Risks opened and closed since 19th October 2011

ID	Title	Description	Risk level	Opened	Closed date	Reason
1177	Achievement of CQUIN for Heart Failure Improvement and reduction in readmissions for patients with Heart Failure. Value 160K	Currently patients diagnosed with Heart Failure are not consistently managed across the Trust and are not consistently referred if appropriate to Community Heart Failure Services, thus minimising potential readmission to hospital and optimising patient care.	HIGH	2-Nov-2011	8-Dec-2011	Dec 11: RISK CLOSED. This risk is to be subsumed by a corporate risk for ALL CQUINS for 2011-12. Risk to be raised by Matthew Tambling, Business Development.

Increase in risk level

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
1147	The use of escalation beds Trust wide compromises patient safety and dignity	Significant capacity issues affecting both hospitals which has meant escalation beds are necessary and sometimes located in areas not routinely used for in-patient activity and therefore do not always provide the best quality experience. Some examples of impact upon elective surgery and procedures are noted. This represents poor patient experience -it also has an impact on the Trust finances and external targets.	**Nov 11: All mitigations from previous update continuing. However, the likelihood of risk has increased, therefore risk score raised from Medium 6 to High 12.** **Jan 12: The risk to patient safety related to the escalation of beds is reduced; however, the risk should remain at high until all mitigating factors are in place. Permanent staff in place and ward manager position secure. Matron cover increased with sound focus on the escalation areas. Consultant and therapy cover being actioned to ensure robust continuity and stability to maintain the flow. Day Surgery increased at Ashford and Day Surgery unit at SPH now used for cardiology angios.**	MEDIUM 6	HIGH 9	Executive Director: Suzanne Rankin Contact: Vanessa Avlonitis

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
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.	**Jan 12: The key risk is delivery of a maximum waiting time of 4 hours in A&E as the Trust failed to meet this standard during Q3. As a result, the recovery plan has been reviewed and revised and the leadership team has been strengthened to support delivery. (A copy of the plan is held in the Quality Dept)**	HIGH 9	HIGH 12	Executive Director: Valerie Bartlett Lead Manager: Valerie Bartlett Contact : Claire Braithwaite

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
1037	Failure to monitor and review compliance with CQC regulations.	If we fail to monitor and review compliance with CQC regulations then the organisation will, at worst, fail to meet the essential standards of compliance. The most severe regulatory response to this would be a de-registration of services and/or legal action.	**Jan 12: The Care Quality Commission (CQC) carried out a review at ASPH on the 1 December 2011 and a draft report has been received. Outcomes 1,2,4,7,14 & 16 were inspected and some minor/ moderate & major concerns were raised in their initial response. A detailed action plan has been agreed by the Executive team and the Trust is now awaiting the final report from the CQC. The risk has been raised to High.**	MED 6	HIGH 12	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle

Reduction in risk level

ID	Title	Description	Reason	Previous level	Current 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.	**Jan 12: The pilot for the Code 5 Tracker finished in December. Lessons learned to date have been incorporated into the functionality and deployment across the Trust will commence in Paediatrics. As deployment progresses, the functionality will be enhanced as feedback from clinicians is received.** **It is recommended that the status for this alert remain at amber until such time that the Code 5 Tracker is deployed across the Trust. It is estimated that deployment will be completed by end February 2012.**	HIGH 8	MEDIUM 6	Executive Director: Suzanne Rankin Lead Manager: David Fluck

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
1130	Lack of assurance of robust adult safeguarding procedures	There is inadequate assurance that safeguarding concerns from external partners particularly around discharge of vulnerable patients are being adequately addressed. Low numbers of staff have received adult safeguarding training.	**Jan 12: Risk reduced to 9. Safeguarding training progressing with 70% of staff trained. Deprivation of Liberty (DOLS) and Mental Capacity Act (MCA) training organised for February and March, communications sent out to all who need to attend. New database designed to capture data for safeguarding concerns to go live in February. Policy and process for escalation complete.**	HIGH 12	HIGH 9	Executive Director: Suzanne Rankin Key Personnel Vanessa Avlonitis & Susan Brown

Summary of Corporate Risks as at 18th January 2012

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risks							
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	HIGH	12	TREAT	12-Mar-2008	18-Apr-2012	Executive Director: Valerie Bartlett Lead Manager: Claire Braithwaite
832	Loss of income-Contracts. (BAF 3.4)	HIGH	12	TREAT	26-Mar-2009	25-Jan-2012	Executive Director: John Headley Lead Manager: Stephen Hepworth
1150	Underperformance of CIP Programme in 2011/12	HIGH	12	TREAT	29-Jun-2011	15-Feb-2012	Executive Director: John Headley Key Personnel : Valerie Bartlett; Paul Gilmore and Mark Hinchcliffe
1072	Discharge process has identified risks to vulnerable patients	HIGH	12	TREAT	2-Sep-2010	15-Feb-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1128	Capacity issues affecting quality of care for patients in AE	HIGH	12	TREAT	31-Mar-2011	7-Mar-2012	Lead Manager:Deb Sutton Key Personnel: Marcus Wootten and Vijay Gautam
1129	28 day readmission rate	HIGH	12	TREAT	31-Mar-2011	25-Jan-2012	Lead Manager: David Fluck
1113	Fraud and Corruption	HIGH	10	TREAT	2-Feb-2011	25-Jan-2012	Executive Director: John Headley Lead Manager: Miriam Moore
1130	Lack of assurance of robust adult safeguarding procedures	HIGH	9	TREAT	31-Mar-2011	7-Mar-2012	Executive Director: Suzanne Rankin Key Personnel :Vanessa Avlonitis & Susan Brown
1037	Failure to monitor and review compliance with CQC regulations.	HIGH	12	TREAT	16-Jul-2010	18-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle
1147	The use of escalation beds Trust-wide compromises patient safety, privacy and dignity.	HIGH	9	TREAT	12-Jun-2011	14-Mar-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	MED	6	TREAT	2-Feb-2011	18-Mar-2012	Executive Director: Suzanne Rankin Lead Manager: David Fluck
1083	Corporate lack of Trust Social Services worker post for Paediatric services	MED	6	TREAT	21-Sep-2010	11-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Jacqui Rees

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ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	18-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	28-Feb-2012	Executive Director: Suzanne Rankin Lead Manager: Sal Maughan
1153	Privacy & Dignity issues for service users in the CDU/Pit Stop within the ED department	MED	6	TREAT	17-Aug-2011	18-Apr-2012	Executive lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	MED	6	TREAT	12-Mar-2008	18-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	15-Feb-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Sal Maughan
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	25-Jan-2012	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 18th January 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											
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. March 2011 - negotiate terms of new 2011/12 contract. Fast Steady Stop task group set up. Action plan monitored.	12	HIGH	26-Mar-2009	25-Jan-2012	*Previous Action Plan/s held on paper in the Quality department.* June 11: Brief DGMs and seek views on impact of new contract penalties and CQUIN for 11/12. Brief TEC and Board in June 2011 - contract terms, risks and penalties. Repeat briefing for DGMs to cascade. Negotiate revisions to PCT Daycase/OP procedure levy. Shadow-monitor bought-out challenges in year 11/12. Continue prior approvals process and C2C referal monitoring with Thames Medical. **August 11: Finalise the Trust's proposed business rules for OP Procedure vs Daycase contract challenge and send to PCT, to apply to M4 data.** **Seek second review of prior approvals process with Thames Medical.**	*All previous updates held on paper by the Quality department.* Sept 11: Seeking agreement with PCT on Readmissions penalty and Non elective threshold Oct 11: - Review data challenge documentation to ensure process is followed - Work with PMO to ensure project plans in place for all CQUINS - Focus on ensuring Q1 closed and by end of month all previous months data challenges returned to PCT **Nov 11:** **- Seek to refocus resource on data challenges in conjunction with Finance and Information departments** **- In half year reviews ensure that all department leads are achieving CQUIN outcomes** **- Innitate process of managing activity to contract levels with the Division** **Dec 11: No change**	6	MED	Executive Director: John Headley Lead Manager: Stephen Hepworth

Corporate Risk Register as at 18th January 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	12	HIGH	2-Sep-2010	15-Feb-2012	*Previous Action Plan/s held on paper in the Quality department.* **Oct 11: On-going discharge training for ward MDT teams to support improved understanding of roles & responsibilities relating to discharge. Daily 8am board rounds supports coordination of MDT discharge priority planning.** **Discharge competency now ratified and waiting for roll-out via discharge team & CPEs to all wards**	*All previous updates held on paper by the Quality department.* **Oct 11: Discharge dash board monitoring medically fit patients with excess bed days, delays in HNA completion, EDD compliance. New Real time plan for improved understanding of where patients are in their discharge pathway including blocks to discharge.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Corporate Risk Register as at 18th January 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1128	Capacity issues affecting quality of care for patients in AE	Due to lack of capacity and patient flow some patients are waiting for prolonged periods in the A&E department whilst the department continues to receive patients from the community. The department is unable to work efficiently to meet the many and varied needs of large numbers of patients. The quality of care and treatment provided at these times is therefore at risk of degradation.	12	HIGH	31-Mar-2011	7-Mar-2012	**March 2011 - Work with partners to reduce external demand on the A&E department (SECAMB and GPs).** **Internal Trust work to review and refine emergency and acute pathways to improve patient flow.** **Matron to review management of ambulance patients in the queue and consider co-horting to a safe ""surge"" area.** **ED Consultant to review medical team management and referral processes.** **Escalation policy to secure additional staff and resource to the department as required.** **Regular medical review of those patients with decision to admit.** **Prioritisation to move patients when beds become available on a clinical severity basis.** **Escalation of all patients requiring a specialist bed.**	Nov 11: Ambulatory pathways and New Medical Model now in place. However, capacity still significant issue. Risk level unchanged. **Jan 12: A&E work streams for quality and safety in progress. New Clinical decision Unit opened for A&E which is effective. Pitstop functioning well with good communication with community partners SECAM. Escalation process agreed and launched. Standard criteria for patients referral to specialities launched. Two hourly board rounds introduced. A&E now being led by the Deputy Chief Nurse. Band 7 responsibilities have been identified and a senior nursing position being considered to include service management responsibilities, to be advertised in February.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Deb Sutton
1129	28 day readmission rate	High readmission rate indicative of poor quality. requirement to eliminate elective-emergency admissions and reduce emergency-emergency rate by 25% .	12	HIGH	31-Mar-2011	25-Jan-2012	March 11: Enhancing Quality pathways working to monitor and reduce readmissions for heart failure, pneumonia, Acute Myocardial Infarctions, Hips and Knees. North West Surrey working to reduce readmissions through enhanced joint working. Monitoring readmissions and examining themes by divisions at Clinical Governance Committee.	May 11: Introduction of virtual ward projects and Nursing home review project in process. Aug 11: No change Oct 11: No change **Dec 11: No change**	3	LOW	Lead Manager: David Fluck

Corporate Risk Register as at 18th January 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1150	Underperformance of CIP Programme in 2011/12	The financial strategy of the Trust requires overall savings of £12m in 2011/12. Underachievement of £12m would lead to the financial plan not being achieved, with a failure to obtain a Monitor financial risk rating of 3 at year end, and a further risk to the financial sustainability of the Trust.	12	HIGH	29-Jun-2011	15-Feb-2012	Sept 11: Developed roadmap to £12m. Currently at £10.6m. Additional person brought in to help with process. Meetings now biweekly for challenged divisions. **Nov 11: CIP plans continually monitored, performance issues addresses and substitute schemes identified where necessary including over-performance in some areas to compensate**	Sept 11: Enhanced governance process around new CIPs. £10.6m expected forecast at Month 5 against target of £12m. Nov 11: If underperformance of CIP occurs, it is likely to be relatively small, currently forecast @ C.95% plan presenting a moderate risk. Work continues to bridge the forecast gap which will continue to mitigate overall risk. **Jan 12: Specific scheme target in addition to overall review and control of CIPS. Further encouragement of performing areas is helping to create additional CIPS to stem some of the larger schemes underachievement.**	3	LOW	Executive Director: John Headley Key Personnel: Valerie Bartlett; Paul Gilmore and Mark Hinchcliffe

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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	18-Apr-2012	*All previous updates held on paper by the Quality department.* Aug 11: Key risk is performance against the Clinical Quality Indicators for A&E. The action plan to address this forms part of the unscheduled care project. Other actions to mitigate the risk include: - A daily breach review meeting with A&E - A formal, executive-led weekly review of the A&E action plan - A weekly operational performance meeting chaired by the Associate Director for Performance Improvement. **Jan 12: The key risk is delivery of a maximum waiting time of 4 hours in A&E as the Trust failed to meet this standard during Q3. As a result, the recovery plan has been reviewed and revised and the leadership team has been strengthened to support delivery. (A copy of the plan is held in the Quality Dept)**	*All previous updates held on paper by the Quality department.* July 11: Whilst the Trust delivered its Q1 performance, from Q2 the indicators change and there are risks over three of these indicators - failue to deliver more than two indicators will drop the Trust to amber green performance and ideally the Trust is seeking to deliver on all five. Three standards remain at risk during this quarter: (1) 95th percentile on total time (2) Unplanned reattendance rate and (3) 95th percentile for initial assessment *(more detailed information given on update form)* Further action will be developed on the back of the breach analysis which is due to complete by 18th July 2011. August 11: See Action Plan October 11: The Trust has achieved an overall performance rating of green for quarter 2. It is anticipated that this level of performance will continue in quarter 3, although ensuring that 95% of patients spend less than 4 hours in the A&E Department remains a risk. **Jan 12: See Action Plan**	4	MED	Executive Director: Valerie Bartlett Contact: Claire Braithwaite

Corporate Risk Register as at 18th January 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	25-Jan-2012	*Previous Action Plan/s held on paper in the Quality department.* April 11: In addition to the actions already recorded, the Trust's intranet pages on Counter Fraud have now been updated and publicised via the Aspire e-bulletin, a presentation has been made at the Trust's Team Briefing and work has commenced on preparing the Trust for the impending implementation of the Bribery Act 2010. July 11: The Bribery Act 2010 is now in force and the LCFS has been developing guidance, training and proposed policy updates to be issued shortly, subject to agreement through the normal channels.	July 11: The risk score has been reviewed and is unchanged. Preventative activity is ongoing as described in the action plan. The report and evidence for the 2010/11 Qualitative Assessment was submitted to NHS Protect (formerly the NHS Counter Fraud and Security Management Service) by the deadline of 6th May 2011. A provisional score and report is not expected until November 2011 with the final score and report not likely to be issued until early 2012. Aug 11: No change **Oct 11: We are still waiting for the provisional results of the Qualitative Assessment for 2010/11. Meanwhile, NHS Protect has confirmed that there will be no qualitative assessment process for 2011/12 and that a consultation will be undertaken before the process is redesigned.** **Dec 11: No change**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 18th January 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1130	Lack of assurance of robust adult safeguarding procedures	There is inadequate assurance that safeguarding concerns from external partners particularly around discharge of vulnerable patients, are being adequately addressed. Low numbers of staff have received adult safeguarding training. May 11: Heads of Nursing now taking the lead for delivery of operational safeguarding pollicy, procedures and practice within Divisions. First action to be Divisional Review with assessment and improvment plans by 30 June 11. Corporate Activity to be focused in 3 areas: 1. Training. 2. Corporate Leadership. 3. Engagement and multi-agency working. Corporate action plan to be drafted by 27 May 11	9	HIGH	31-Mar-2011	7-Mar-2012	March 11: Review in detail adult safeguarding concerns and processess and establish an action plan to deliver improvements. Assess the inadequate training numbers, establish training programme and plans for delivery. Adult safeguarding Committee to oversee improvements. **Oct 11: Safe Guarding medical lead approached- to be confirmed.**	Oct 11: Training well underway. We now have 1800 staff trained. Further training sessions organised for the rest of the year. Two subgroups formed for training and policy development. Policy currently in review which will be more user friendly and support staff in escalating concerns. **Jan 12: Risk reduced to 9. Safeguarding training progressing with 70% of staff trained. Deprivation of Liberty (DOLS) and Mental Capacity Act (MCA) training organised for February and March, communications sent out to all who need to attend. New database designed to capture data for safeguarding concerns to go live in February. Policy and process for escalation complete.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

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1147	The use of escalation beds Trust wide compromises patient safety and dignity	Significant capacity issues affecting both hospitals which has meant escalation beds are necessary and sometimes located in areas not routinely used for in-patient activity and therefore do not always provide the best quality experience. Some examples of impact upon elective surgery and procedures are noted.This represents poor patient experience -it also has an impact on the Trust finances and external targets.	9	HIGH	17-Jun-2011	14-Mar-2012	Immediate actions include: - Making sure patients are accommodated in the right place, and not in escalation areas. - Moving as much planned activity as possible to Ashford, with the right support, so St Peter's can concentrate on acute care. - Making sure we manage our beds in a better way so we don't have to keep moving patients around our wards. - That staff understand what the alternatives to acute admission are and that they know how to access these services. - Improving our multi-disciplinary ward rounds and discharge processes.	Aug 11: Risk level downgraded to medium 6 due to the following: - 95% of escalation areas are now closed - Introduction of new capacity procedures - Introduction of the CDU (Nov 2011) - New medical outlier policy (to be ratified) - Introduction of ambulatory care pathways will redirect patients away from hospital - Introduction of new Standard operational policy for MAU Nov 11: All mitigations from previous update continuing. However, the likelihood of risk has increased, therefore HIGH risk score reinstated. **Jan 12: The risk to patient safety related to the escalation of beds is reduced, however, the risk should remain at high until all mitigating factors are in place. Permanent staff in place and ward manager position secure. Matron cover increased with sound focus on the escalation areas. Consultant and therapy cover being actioned to ensure robust continuity and stability to maintain the flow. Day Surgery increased in Ashford and Day Surgery unit at SPH now used for cardiology angios.**	3	LOW	Executive Director: Suzanne Rankin Contact: Vanessa Avlonitis

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1112	Failure to act on radiological imaging reports resulting in missed diagnosis	NPSA 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.	6	MED	2-Feb-2011	18-Apr-2012	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)*	**Jan 12: The pilot for the Code 5 Tracker finished in December. Lessons learned to date have been incorporated into the functionality and deployment across the Trust will commence in Paediatrics.** **As deployment progresses, the functionality will be enhanced as feedback from clinicians is received.** **It is recommended that the status for this alert remain at amber until such time that the Code 5 Tracker is deployed across the Trust. It is estimated that deployment will be completed by end February 2012.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: David Fluck

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ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1083	Corporate lack of Trust Social Services worker post for Paediatric Services	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. **July 11: The wording of above has been looked at by Paul Crankshaw, who has decided that the risk desription does not need to be re-written.**	6	MED	21-Sep-2010	11-Apr-2012	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.	*All previous updates held on paper by the Quality department* Mar 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. Paediatric Consultants asked to complete incident form when they feel that the absence of a hospital paediatric social worker or the lack of results filing in the notes has caused any sort of problem. July 11: Exploring development of a further safeguarding post to support Named Nurse. Nicky Love & JA Dowie to compile job description for this post. Sept 11: Risk closed (Helen Sibley) Oct 11: Risk reopened (Suzanne Rankin) until post filled. **Jan 12: An alternative approach has been agreed with the Safeguarding team. A nurse is to be employed to assist the Lead Child Protection nurse. Interviews taking place this month. Risk will be removed when post is filled.**	3	LOW	Executive Director: Suzanne Rankin Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby

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1037	Failure to monitor and review compliance with CQC regulations.	If we fail to monitor and review compliance with CQC regulations then the organisation will, at worst, fail to meet the essential standards of compliance. The most severe regulatory response to this would be a de-registration of services and/or legal action.	12	HIGH	16-Jul-2010	18-Apr-2012	*All previous updates held on paper by the Quality department.* **Jan 12:** **1. Strengthening of divisional governance meetings systems and processes.** **2. Regular meetings between the Associate Director of Operations and Associate Director of Quality from January 2012.** **3. Review of Clinical Governance Committee structure, both corporately and at divisional level - March 2012.**	**Jan 12:** **1. AD of Quality meeting with Divisional Directors individually to be completed 26th January.** **2. Regular meetings of AD of Quality and AD of Operations commenced 17th January.** **3. Clinical Governance quality dash boards under review, commenced Dec 2011.** **3.2. Steering committee set up to interrogate and review quality performance in order to drive improvements in clinical effectiveness and patient safety.** **3.3. Closer relationship formed with Doctor Foster and other quality monitoring agencies, such as the Health Observatory.** **The Care Quality Commission (CQC) carried out a review at ASPH on the 1 December 2011 and a draft report has been received. Outcomes 1,2,4,7,14 & 16 were inspected and some minor/ moderate & major concerns were raised in their initial response. A detailed action plan has been agreed by the Executive team and the Trust is now awaiting the final report from the CQC. The risk has been raised to High.**	4	MED	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle

Corporate Risk Register as at 18th January 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	28-Feb-2012	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 11: In addition to the action plan in place, there is a more recently developed 4 week improvement plan in place to treat this risk and clear the current backlog of complaints by mid December. The plan has been approved**	*All previous updates held on paper by the Quality department.* Sept 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 29 July 2011 where a report was presented and it was agreed that the devolved process was not fully embedded. As such the risk remains unchanged. The action plan will continue to be monitored and will be reviewed at the next Complaints Monitoring Group meeting on 4 Nov 2011. **Nov 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 4 November 2011 where a report was presented and it was agreed that the devolved process was not fully embedded. As such the risk remains unchanged. The action plan will continue to be monitored and will be reviewed at the next Complaints Monitoring Group meeting in Feb 2012.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Sal Maughan

Corporate Risk Register as at 18th January 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1153	Privacy and Dignity issues for service users in the CDU/Pit Stop area within the ED department	Financial Loss, Service Failure, Staff Safety, Building / Infrastructure Failure, Failure to meet National targets, Failure of Statutory duty) Potential failure to improve upon Privacy and Dignity issues for service users within the CDU/Pit stop area within the ED. Failure to meet the SSA and risk to Trust	6	MED	17-Aug-2011	18-Apr-2012	Require strict adherence to the reduction and ultimate elimination of the acceptance of mixed sex gender accommodation for patients in the CDU/Pit Stop area for patient awaiting a clinical decision. Currently the Trust is redesigning the ED department. Refurbishment of the new pitstop area to create a CDU will commence early sept 2011. This will be SSA compliant Needs to be kept on the risk register due to capacity pressures until the creation of the new unit. CNSP/Matron for ED will monitor this compliance daily. All ED staff to be made aware of the importance not to breech SSA.	**Oct 11: CDU is currently on target for completion. If pit stop has to be used overnight it has to be single sex compliant, discussions must involve all decision makers.**		LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Corporate Risk Register as at 18th January 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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	6	MED	12-Mar-2008	18-Apr-2012	*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 **March 11: Action Plans have been updated to reflect the current status**	*All previous updates held on paper by the Quality department.* 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. April 11: Since July 2010 the Trust has had no MRSA Bacteraemias and therefore have not breached trajectory for 2010/11. Also Clostriduim difficile rates are significantly below trajectory for 2010/11 Action Plans updated and clinical interventions remain ongoing . Sept 11: Risk level reduced from medium to low. Oct 11: The Trust has now had 2 MRSA bacteraemias (April- September 2011/12) of a trajectory of 4. Vigilance in practice is paramount not to exceed our trajectory. Risk level reverted to medium. **Jan 12: No MRSA bacteraemia since September 11, therefore well under target to date.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead

Corporate Risk Register as at 18th January 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	15-Feb-2012	*All previous updates held on paper by the Quality department.* **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 updates held on paper by the Quality department.* August 11: 10 point plan drafted and implementation ongoing. Increased focus during July - month of patient sampling for inpatient survey. Ongoing surveys: AE (spotlight) and OPD (National). **Oct 11: The Trust has recently received its ['raw' results following the 2011 outpatient survey. These results will be weighted by the CQC to enable benchmarking across all acute Trust. The CQC results are anticipated in January 2012. In the meantime, action planning will commence. In addition, the Living our Values Programme continues.**	6	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Sal Maughan

Corporate Risk Register as at 18th January 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	25-Jan-2012	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.	July 11: The risk score has been reviewed and is unchanged. When the renewal process is started for the Trust's existing top-up insurance for property damage/loss of non-NHS income the cost of cover for loss of NHS income will ascertained and the treatment of this risk reviewed. The renewal date for the existing insurance is 30/11/11 so the renewal process is expected to commence towards the end of Quarter 2. Aug 11: No change Oct 11: No change, apart from a delay in commencing the insurance renewal process. This is now expected to commence before the end of October 2011. **Dec 11: The Trust's existing top-up insurance for loss of non-NHS income was renewed with effect from 01/12/11 but a review of the nee d for cover for loss of NHS income has been delayed and will now take place in Q4 of 2011/12.**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore