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

TRUST BOARD
27th October 2011

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 19th October 2011, and highlights that since 23rd June 2011: • Two risks have been added • One risk where the risk level has changed • Seven risks have been closed; including four risks closed following an exercise commissioned by IGAC to look at all risks on the register which were over a year old. 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:	19th October 2011
Decision:	For Review

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
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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 23rd September 2011. The next meeting is 28th October 2011.

Risks opened since 23rd June 2011

ID	Title	Description	Present Objective	Risk level	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	TREAT	HIGH	Executive Director: John Headley Key Personnel : Valerie Bartlett; Robert Jeffries; Paul Gilmore and Mark Hinchcliffe
1153	Privacy and Dignity issues for service users in the CDU/Pit Stop area within the ED department	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	TREAT	MED	Lead Manager: Richard Lloyd-Booth Key Personnel : Wendy Pulling, Sue Harris-CNSP

Existing Risk where the risk level has changed since 23rd June 2011

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.	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 patient away from hospital - Introduction of new Standard operational policy for MAU	HIGH	MED	Executive Director: Suzanne Rankin Contact: Richard Lloyd-Booth

Risk closed since 23rd June 2011

ID	Title	Description	Risk level	Opened	Closed date	Reason
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.	HIGH	12-Oct-2010	14-Jul-2011	*Previous progress held on paper in the Quality Department* April 11: Level 2 compliance attained over 22 key requirements. However there is a proviso that we meet 30th June deadline regarding 95% of staff on IG Training LEP. June 11: 10/06/11 Approximately 500 staff still to be trained. Active campaign ongoing, closes 24th June, deadline for submission 30th June 2011. Optimistic outlook at present. **July 11: Training target has now been achieved. RISK CLOSED.**
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 March 11: March 11 work being taken forward as part of newly formed PMO.	HIGH	23-Jun-2010	19-Aug-2011	*Previous progress held on paper in the Quality Department* July 11: This risk is being mitigated by: admission avoidance schemes as part of the ambulatory care programme (target is a 10% additional reduction through that programme); review of coding particularly regarding unplanned re-attendances and re-admissions. There has been a step change reduction in both attendances and admissions but not yet to 2008-2009 levels. **Aug 11: RISK CLOSED as it relates to the 2010/11 contract. To be replaced with a new risk.**

ID	Title	Description	Risk level	Opened	Closed date	Reason
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	LOW	12-Mar-2008	15-Aug-2011	*Previous progress held on paper in the Quality Department* May 11: Refurbishment complete. Need to be mindful of new criteria set by the Department of Health regarding Critical care, High Dependency, CCU and MAU areas. **Aug 11: RISK CLOSED. New risk added (1153) regarding compliance with SSA on Pit Stop areas.**
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.	MED	12-Mar-2008	14-Sep-2011	*Previous progress held on paper in the Quality Department* Aug 11: 1. Sustained downward trend in qualified nurse vacancies continues. 2. 17 Overseas Nursing Programme candidates successfully completed course and now practising as registered nurses. 3. Review of Ward establishments complete and reconciled. 4. A&E Delivery Plan agreed following development sessions in July/August 2011. Enhanced medical bank rates extended to mitigate agency expenditure. Consultant recruitment campaign to take place in September. 5. Midwife vacancy rate will be c.5% once confirmed appointments have commenced. **Sept 11: RISK CLOSED (Jeremy Over)**

ID	Title	Description	Risk level	Opened	Closed date	Reason
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers.	MED	26-Mar-2009	14-Sep-2011	*Previous progress held on paper in the Quality Department* 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. May 11: Timetable for award is September 2011 with ITT to be published by June 2011. InHealth have agreed to a contract extension to cover the tender period mitigating the risk. August 11: Proceeding as planned. **Sept 11: RISK CLOSED (Valerie Bartlett)**
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.	MED	27-Oct-2008	14-Sep-2011	*Previous progress held on paper in the Quality Department* May 2011: The policy database shows 68% compliance of in date policies. Patient care and nursing procedures remain the highest numbers of policies out of date. An action plan is being worked through to address the shortfall. July 11: Current review indicates Trust compliance at 72%. All owners of outdated policies to be contacted requesting details of plan for update. In addition, owners will be advised of Chief Executive request that he be advised of details of outdated polices. A summary will be forwarded to the Chief Executive by the end of August 11. **Sept 11: RISK CLOSED (Jill Down)**

ID	Title	Description	Risk level	Opened	Closed date	Reason
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)	MED	9-Apr-2009	14-Sep-2011	*Previous progress held on paper in the Quality Department* March 11: Psychiatric liaison increased from 08.00 - 20.00 Interface meetings between Psychiatric services and A&E staff continuing Psychiatric liaison team being given space in the A&E department to work which further improves working relations. June 11: In consultation with Psychiatric colleagues we have reduced the number of referrals forms from 3 to 2. This has made access simpler for staff and reduced risk of patient being referred inappropriately. **Sept 11: RISK CLOSED (Valerie Bartlett)**

Summary of Corporate Risks as at 19th October 2011

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	11-Jan-2012	Executive Director: Valerie Bartlett Lead Manager: Claire Braithwaite
832	Loss of income-Contracts. (BAF 3.4)	HIGH	12	TREAT	26-Mar-2009	7-Dec-2011	Executive Director: John Headley Lead Manager: Sue Robertson
1072	Discharge process has identified risks to vulnerable patients	HIGH	12	TREAT	2-Sep-2010	16-Oct-2011	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	2-Nov-2011	Lead Manager: Charlotte Freeman Key Personnel: Wendy Pulling and Vijay Gautam
1129	28 day readmission rate	HIGH	12	TREAT	31-Mar-2011	23-Nov-2011	Lead Manager: Mike Baxter
1130	Lack of assurance of robust adult safeguarding procedures	HIGH	12	TREAT	31-Mar-2011	16-Oct-2011	Executive Director: Suzanne Rankin Key Personnel :Vanessa Avlonitis & Susan Brown
1150	Underperformance of CIP Programme in 2011/12	HIGH	12	TREAT	29-Jun-2011	31-Oct-2011	Executive Director: John Headley Key Personnel : Valerie Bartlett; Robert Jeffries; Paul Gilmore and Mark Hinchcliffe
1113	Fraud and Corruption	HIGH	10	TREAT	2-Feb-2011	7-Dec-2011	Executive Director: John Headley Lead Manager: Miriam Moore
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	HIGH	8	TREAT	2-Feb-2011	23-Nov-2011	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.
1083	Corporate lack of Trust Social Services worker post for Paediatric services	MED	6	TREAT	21-Sep-2010	7-Dec-2011	Executive Director: Suzanne Rankin Lead Manager: Jacqui Rees
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	4-Nov-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	30-Nov-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down

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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: Richard Lloyd Booth
1147	The use of escalation beds Trust-wide compromises patient safety, privacy and dignity.	MED	6	TREAT	12-Jun-2011	10-Nov-2011	Executive Director: Suzanne Rankin Lead Manager: Richard Lloyd Booth
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	MED	6	TREAT	12-Mar-2008	12-Jan-2012	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	9-Nov-2011	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down
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	7-Dec-2011	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 19th October 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	7-Dec-2011	*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.* August 11: Work done to develop a set of clinically meaningful business rules to meet the OP procedure/daycase challenge. To be applied to M4 data. Briefings to TEC and Board completed, shared with DGMs. Prior approvals and C2C processes to be discussed with Thames Medical. **Sept 11: Seeking agreement with PCT on Readmissions penalty and Non elective threshold** **Oct 11: Review data challenge documentation to ensure process is followed** **Oct 11: Work with PMO to ensure project plans in place for all CQUINS** **Oct 11: 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** **Nov 11: In half year reviews ensure that all department leads are achieving CQUIN outcomes** **Nov 11: Innitate process of managing activity to contract levels with the Division**	6	MED	Executive Director: John Headley Lead Manager: Sue Robertson

Corporate Risk Register as at 19th October 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	16-Oct-2011	July 11: 1. Discharge training programme April - Oct 2011 for all ward nurses and MDT 2. MDT Coordinated am board rounds. 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. Change of Clinician start times from 9am - 8am to support early decision-making including TTO writing etc 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 staff. 9. Managing expectations of family and carers working in partnership. 10. End of Life Care pathway 11. Outlying support team to focus on escalation areas 12. Winterplanning and capacity; ensuring robust planning for Dr & nurse support to COE 13. Nurse leadership (new band 6 post to focus on and be accountable for discharge practices at ward level)	*All previous updates held on paper by the Quality department.* 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. March 11: Please note the risk has been reassessed and increased to 12 due to intelligence around discharge issues such as complaints, PALS and Safe Guarding Adults. July 11: See revised Action Plan **Sept 11: Action plan continuing.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

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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	2-Nov-2011	**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.**	May 2011: This risk is currently being reviewed by the Chief Nurse and management team with respect to broadening the risk. June 11: Risk remains at the same level. A second Trust wide risk had been added to the risk register regarding use of escalaltion beds. **Sept 11: Risk level remains unchanged at present. Work with the ambulatory care pathways and with other outside agencies will eventually reduce the numbers, as will the MAU project but the department is still full most days.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Charlotte Freeman

Corporate Risk Register as at 19th October 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	12	HIGH	31-Mar-2011	16-Oct-2011	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.	May 11: A scoping exercise is being undertaken to ascertain and enable an accurate estimation of training requirement and associated resourcing. July 11: Action plan developed and in place. Training dates in July have to date resulted in 320 employees trained in safeguarding. 2 further dates in July, and 2 dates per month thereafter. Induction reviewed and in place for safeguarding from July. Plans to incorporate the current learning disability training into safeguarding training. Target for the end of December will be for 90% of front line staff to have had training. DCN has reviewed the TOR of the safe guarding steering group to oversee Safe Guarding within the Trust. JD for Safe Guarding Nurse in progress. Excellent multiagency links. **Sept 11: Action plan ongoing. Good progress being made.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

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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	31-Oct-2011	June 11: A full review of the CIP programme, including projects under the Programme Management Office (PMO) to be carried out after Month. Detailed CIP meetings to take place between executive directors and those divisions with significant forecast shortfalls. Weekly executive finance meetings to scrutinise CIP plans and to measure progress on a weekly basis. Contingency of £2m to be found to assist in covering any potential shortfall. Incentives for CIP over-performance to be confirmed. **Sept 11: Developed roadmap to £12m. Currently at £10.6m. Additional person brought in to help with process. Meetings now biweekly for challenged divisions.**	August 11: Many plans which are not robust have been discarded or reduced in value. Expected forecast value of £10m at Month 4 (ie £2m shortfall). Further plans to come on stream in August / September. **Sept 11: Enhanced governance process around new CIPs. £10.6m expected forecast at Month 5 against target of £12m.**	3	LOW	Executive Director: John Headley Key Personnel : Valerie Bartlett; Robert Jeffries; Paul Gilmore and Mark Hinchcliffe Contact: Robert Jeffries
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	23-Nov-2011	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.	Sept 11: Enhanced governance process around new CIPs. £10.6m expected forecast at Month 5 against target of £12m.	3	LOW	Lead Manager: Mike Baxter

Corporate Risk Register as at 19th October 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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	7-Dec-2011	*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.**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 19th October 2011

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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.	9	HIGH	12-Mar-2008	11-Jan-2012	*All previous updates held on paper by the Quality department.* July 11: Current action plan addresses backlog to deliver the 23 week standard for Monitor Compliance Framework. A revised action plan is being developed to also meet the 18 week requirement in the contract with NHS Surrey - costs are estimates until that plan is completed for end of July 2011. 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.	*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.**	4	MED	Executive Director: Valerie Bartlett Contact: Claire Braithwaite

Corporate Risk Register as at 19th October 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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.	8	HIGH	2-Feb-2011	23-Nov-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)*	April 11: Andrew Davis an IT consultant has been working on an IT solution in liaison with two of the divisional directors. The system is called the code 5 tracker and will interface between PAS & CRIS to pick up any code 5 reports. The reports then need to be signed of by the referrer or clinician who is currently caring for the patient. The system has a full audit trail and will be monitored by Radiology. The prototype is near completion with a demonstration planned for Friday the 6th May 2011. June 11: Automated system now devised. Implementation now being planned. To go live July 2011. August 11: No change **October 11: Automated system to go live December 2011. A&E ,Respiratory Medicine, Rheumatology, Upper GI, Surgery, Vascular Surgery, Colorectal Surgery & Gastroenterology specialties have agreed to participate in piloting the new Code 5 tracker system. Arrangements to provide training for staff in the use of the system and the new process for tracking Code 5 alerts is progressing.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter

Corporate Risk Register as at 19th October 2011

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	7-Dec-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.	*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)**	3	LOW	Executive Director: Suzanne Rankin Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby

Corporate Risk Register as at 19th October 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	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.	6	MED	17-Jun-2011	10-Nov-2011	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**	3	LOW	Executive Director: Suzanne Rankin Contact: Richard Lloyd-Booth

Corporate Risk Register as at 19th October 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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	9-Nov-2011	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 updates held on paper by the Quality department.* Jan 11: . May 2011: QRP high level summary continues to indicate no red or amber risks for the Trust from CQC perspective. Owners of standards have been reminded of the importance of ensuring ongoing review of Trust evidence and that this is loaded onto the Trust database with quarterly review with the standard owner. The Trust aim is to ensure all evidence is loaded onto the Trust database by the end of May with development of action plans where appropriate. **August 11: Ongoing work to ensure evidence on Trust database (Performance Accelerator) regularly reviewed and updated and Trust assessed compliance reviewed and update against Trust Quality Risk Profile. Progress updated at IGAC. Information booklet on importance and relevance of CGC standards recently distributed to every member of staff. Chief Nurse briefing sessions with senior Divisional Leads. Ongoing scrutiny of Divisional compliance against CQC standards at CGC.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down

Corporate Risk Register as at 19th October 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	30-Nov-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.**	*All previous updates held on paper by the Quality department.* June 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 6 May 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 29 July 2011. **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.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down

Corporate Risk Register as at 19th October 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 to involve all decision makers.**		LOW	Executive Director: Suzanne Rankin Lead Manager: Richard Lloyd-Booth

Corporate Risk Register as at 19th October 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	12-Jan-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 raised back to medium.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead

Corporate Risk Register as at 19th October 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	9-Nov-2011	*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.* 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. May 11: Latest national inpatient survey results (2010) indicate an improved position. Importance of national surveys need continued and sustained emphasis as Trust moves into the next survey period, sampling outpatients in May 11 and inpatients July 11. Corporate and divisional action plans in place. **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).**	6	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down

Corporate Risk Register as at 19th October 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	7-Dec-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.	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.**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore