Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
24th June 2010

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 16th June 2010, and highlights: • 0 New Risk added since 29th April 2010 • 0 Risk with changed treatment objectives since 29th April 2010 • 1 Risk closed since 29th April 2010 • 3 Existing Risks where the risk level has changed since 29th April 2010. This includes the increase of risk 763 relating to HCAI and target requirements, being raised to an extreme risk with a rating of 16. Immediate action has been taken to mitigate this risk however it is now likely this risk will come to fruition, and necessary for the high level of controls to be rigorously maintained and monitored before the risk can be considered being downgraded. This would occur after 1 or two months have passed without an MRSA This report now includes a Target Risk Score should all the mitigating actions be successfully achieved.
ASSURANCE (Risk) / IMPLICATIONS	The Corporate Risk Register report provides assurance that relevant risks have been identified as corporate risks and by doing so there are action plans in place to mitigate the risk. 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, as well as ALE. It is a fundamental requirement of Monitor when the Trust becomes a Foundation Trust.
The Trust Board is asked to:	The Trust Board is asked to note the contents of the Corporate Risk Register.
Submitted by:	Marty Williams, Clinical Risk Manager On behalf of, Caroline Becher, Chief Nurse
Date:	24th June 2010
Decision:	For Noting

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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 9th April 2010

Existing Risks where the risk level has changed since 29th April 2010

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1B)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions	June 10: Four internal cases of MRSA for the first quarter (Apr to Jun) but the target is five for the whole year. This has implications for the FT application, safety of patients and not achieving national targets. Risk changed to extreme.	MED	EXTREM	Executive Director: Caroline Becher Contact: Linda Fairhead
767	Privacy and Dignity issues for service users. (BAF 1e)	Potential failure to improve upon Privacy and Dignity issues for service users.	Mar 10: All required areas should be single sex compliant by the end of March 2010. June 10: Bed remodelling continues but all areas are now virtually compliant with the delivery of single sex accomodation. Risk reduced to Medium.	HIGH	MED	Executive Directors: Caroline Becher Contact: Sue Brown
766	Patient satisfaction scores. (BAF 1d)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	March 10: Remains a high priority. Matrons now high profile with new uniforms and expected to be actively available to patients. Latest data being processed. June 10 1. Ratified Comms and Engagement Strategy. 2. Dashboard for patient satisfaction. 3. Ward quality indicators. 4. Comments cards. 5. Pilot for hand held device undertaken in February. 6. CQUIN Target. 7. 4 Ps Values and Behaviours. 8. Noise at night action plan. 9. Dignity Gowns.	HIGH	MED	Executive Director: Valerie Howell, Caroline Becher Contact: Vanessa Avlonitis, Jill Down

Risk closed since 29th April 2010

ID	Title	Description	Risk level	Opened	Closed date	Reason
890	Failure to implement internal auditor recommendations re patient property	At present the Trust has failed to implement the recommendations of the internal auditor concerning the risk of (a) theft or loss of patient's property (b) identity theft and legal action against the Trust (c) negative publicity in the local press.	MED	6-Aug-2009	16-Jun-2010	June 10: Policy returned by the auditors and their comments incorporated. Additions required by the Quality dept. incorporated. Policy completed and risk closed and agreed by Chancery Velecot Auditors.

Summary of Corporate Risks as at 16th June 2010

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk							
763	Health Care Acquired Infection & National Targets. (BAF 1B)	EXTREME	16	TREAT	12-Mar-2008	17-Aug-2010	Executive Director: Caroline Becher Contact: Linda Fairhead
806	Out of date Trust policies.	HIGH	12	TREAT	27-Oct-2008	20-Jul-2010	Executive Director: Caroline Becher Lead Manager: Sarah Johnston Contact: Tina Hopkins
837	Delay in Psychiatric assessment - A & E and MAU	HIGH	12	TREAT	9-Apr-2009	14-Aug-2010	Executive Director: Valerie Howell Key Personnel: Robert Jeffries, , Heather Clark, Claire O'Brien, Contact: Kate Lawrence, cc Robert Jeffries, Philippa May
988	VTE phrophylaxsis assessment shortfall	HIGH	12	TREAT	25-Feb-2010	10-Aug-2010	Executive Director: Mike Baxter Lead Manager: Clinical Directors Contact: Mike Baxter (Sarah White PA 2839)
764	Delivery on all Performance Targets. (BAF 1a, 1b)	HIGH	12	TREAT	12-Mar-2008	10-Aug-2010	Executive Director: Valerie Howell Contact: Valerie Howell
1006	Failure to comply with CQC registration	HIGH	12	TREAT	14-Apr-2010	2-Aug-2010	Executive Director: Caroline Becher Lead: Sarah Johnston Key Personnel: Essential standards owners, directorate CDs, GMs Matrons and CG managers. Contact: Sarah Johnston
769	Foundation Trust work plan	HIGH	10	TREAT	12-Mar-2008	10/05/2010 Requested 30/04/10	Executive Directors: To be decided Contact: To be decided
768	Staff recruitment and retention. (BAF 2b)	HIGH	9	TREAT	12-Mar-2008	15-Aug-2010	Executive Director: Raj Bhamber Key Personnel: Kate Clarke, Cathy Dennis, Elaine Beaumont, Judy Henville, Harriet Stephens Contact: Raj Bhamber, Kate Clarke
815	Potentially vulnerable network resilience and/or disaster recovery for IT programmes. (BAF 4a)	HIGH	8	TREAT	6-Feb-2009	5-Jul-2010	Executive Director: John Headley Manager: Robin Gammon Contact: Margaret Broomfield, Laura Ellis-Philip
832	Loss of income-Contracts. (BAF 3a)	HIGH	8	TREAT	26-Mar-2009	5-Jul-2010	Executive Director: To be decided Lead: Sue Robertson Contact: Sue Robertson (Head of Planning and Performance)

Summary of Corporate Risks as at 16th June 2010

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
894	Not being licensed for FT status (BAF 3b)	HIGH	8	TREAT	2-Sep-2009	11-Jun-2010	Executive Director: To be decided Lead: To be decided Contact: To be decided
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	15-Oct-2010	Executive Director: Valerie Howell Contacts: Catherine Townsend
816	Failure to develop IT infrastructure appropriately. (BAF 4a)	MED	6	TREAT	6-Feb-2009	2-Jul-2010	Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield
847	Under delivery of CIP programme. (BAF 4b)	MED	6	TREAT	20-May-2009	5-Sep-2010	Executive Director: Valerie Howell Key personnel: Valerie Howell, Barrie Jones, Jenny Johnson, Charlotte Freeman. Contact: Barrie Jones
766	Patient satisfaction scores. (BAF 1d)	MED	4	TREAT	12-Mar-2008	4-Sep-2010	Executive Director: Valerie Howell, Caroline Becher Contact: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1e)	MED	4	TREAT	12-Mar-2008	8-Aug-2010	Executive Directors: Caroline Becher Contact: Sue Brown
907	Service failure- Swine Flu Pandemic	LOW	3	TREAT	16-Sep-2009	4-Jul-2010	Executive Director: Valerie Howell Lead Manager: Valerie Howell Key Personnel: Valerie Howell Contact: Valerie Howell from Jan 10
887	Loss of Person Identifiable Data	LOW	3	TREAT	17-Jul-2009	7-Jul-2010	Executive Director: Mike Baxter Key personnel: Robin Gammon, Alex Williams Lead: Robin Gammon Contact: Alex Williams, Tracy Street
Tolerate: Accept the risk at its current level of risk							
848	Financial loss due to uninsured claims	HIGH	12	TOL	20-May-2009	11-Jun-2010	Executive Director: John Headley Lead: Colin Matthew, John Headley Contact: Colin Matthew
745	IT: Over reliance on key individuals with specialist knowledge.	MED	6	TOL	10-Jan-2008	24-Aug-2010	Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk.											
763	Health Care Acquired Infection & National Targets. (BAF 1B)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions	16	EXTREME	12-Mar-2008	17-Aug-2010	Require more isolation facilities or ability to provide an isolation ward when necessary (at trigger point) whilst striving to without affecting normal business and national targets like 98% and 18 weeks. Aug 09: Assimilated 'Care Quality Commission' visits to wards are being carried out across the trust by Caroline Becher (Chief Nurse) and Linda Fairhead (Consultant Nurse - Infection Control) Nov 09: Ongoing. Root Cause Analysis undertaken for new MRSA bacteraemia and C Diff. May 10: Updated Infection Control Annual Programme for 2010/11 and MRSA and C diff action plan.	Mar 10: MRSA and C diff figures remain on trajectory. All areas now have isolation facilities. Assimilated CQC ward visits continue by the Chief Nurse and Consultant Nurse Infection Control. Risk reduced to medium May 10: The Trust achieved its end of year figures for MRSA Bacteraeamias and C diff below trajectory for 2009/10. New targets have been set for 2010/11. June 10: Four internal cases of MRSA for the first quarter (Apr to Jun) but the target is five for the whole year. This has implications for patient safety, the FT application and not achieving National Targets Risk changed from Medium to Extreme	3	LOW	Executive Director: Caroline Becher Contact: Linda Fairhead
806	Out of date Trust policies.	The Trust policy database has only 13% of its policies in date. (October 08) Risk to patients, staff and service. Non compliance and risk to obtaining Foundation status	12	HIGH	27-Oct-2008	20-Jul-2010	Dec 09: 1. To review progress and plans with the Executive early in 2010. 2. 29% of all policies are for nursing so identify those out of date and investigate the use of the Royal Marsden manual to replace some nursing policies. Mar 10: To monitor HR policies more closely. TH to support Jeremy Overs to clean up current policies and replace. Now establishing owners for out of date nursing policies. May 10: Two 'Policy Days' to be available in Minerva for staff to have support from Quality dept. staff on the updating of policies.	Dec 09: Now 28% in date. Flow of updated policies has slowed, other policies are now out of date, reminders sent. Finance, H&S, risk almost complete. HR still have 78 policies to update out of a total of 119. Mar 10: Continued progress with HR Policies. Finance, organisational, employment and risk management still have 73 out of 116 policies out of date. Currently 33% of policies are now in date. A new intranet page developed providing clear indication to owners of their policy 'in date' status to drive a more proactive approach by the owners. May10: Progress is very slow with in date policies now at 35%.	4	MED	Executive Director: Caroline Becher Lead Manager: Sarah Johnston Contact: Tina Hopkins

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	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)	12	HIGH	9-Apr-2009	14-Aug-2010	1. Escalation of concerns/ ris 2. Develop a risk assessment form which would be completed in A & E / MAU prior to referral to psychiatric services. 3. Urgent review of psychiatric services now in progress. Mar 10: No change. A meeting is to be arranged with the Psychiatric team to discuss the issues.	Mar 10: No progress. June 10: Emergency Services met with Lucy O'Meara (new Services Manager for Surrey & Borders Trust). She acknowledged the lack of responsiveness and will be increasing the number of psychiatric nurses from 1 to 3 by August 10. This will provide evening cover but not as yet weekend cover. She would like SPH to commission 3 PAs per week of Consultant Psychiatric time and for the team to be based on-site. Rebecca Carlton is organising a follow up meeting to explore this further.	2	LOW	Executive Director: Valerie Howell Key Personnel: Robert Jeffries, , Heather Clark, Claire O'Brien, Contact: Robert Jeffries cc Philippa May
988	VTE phrophylaxsis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	12	HIGH	25-Feb-2010	10-Aug-2010	1. Establish VTE implementation group. 2. Change in prescription charts. 3. Increased policing by matrons and senior doctors. 4. On-going audit and review. 5. Direct addressing of under performance. 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 ay monthly performance meetings.	Promotional e-mail concerning VTE sent to all senior nurses on 31st March June 10: Recent audit shows Trust compliance now at 68%. The new pharmacy form is about to be launched.			Executive Director: Mike Baxter Lead Manager: Clinical Directors Contact: Mike Baxter (Sarah White PA 2839)

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
764	Delivery on all Performance Targets. (BAF 1a, 1b)	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 throughout 2009.	12	HIGH	12-Mar-2008	10-Aug-2010	May 2009 1. Detailed action plan in place to improve A and E performance. Weekly improvement meetings in place chaired by the ED. Key actions include workforce development; primary care at the 'front door' 2. In terms of 18 weeks, key actions are to provide outpatient clinic, theatre and ward activity to sustain patient's pathways of access in less than 18 weeks. 3. Full review of demand and capacity for all elective specialties. Feb 10: Closer working between patient pathway team and directorate to improve performance in orthopaedics and improve booking practice. Some outsourcing of work. Recovery plan in terms of four hour target focused on medical staffing at peak times and improved management capacity.	Feb 10: Orthopaedics expected to deliver Q4 on admitted and non admitted pathway. Significant in year improvement in A&E performance is being maintained. Apr 10: Progress against all key performance targets is strong and on track for the remainder of the financial year. Performance in Feb. and Mar. has been at the required level. May 10: The Trust delivered a strong performance against all targets at year end 2009/10 and has now shown the ability to deliver most targets on a sustainable basis. However, this will require continued effort.	4	MED	Executive Director: Valerie Howell Contact: Valerie Howell
1006	Failure to comply with CQC registration	The new regulatory process (Quality Control Commission) is in place from April 2010. There is a change of approach with a focus on standards and with more complex processes required to assure that all regulated activities at both hospital locations meet all required standards. Risk to patients and staff, Trust reputation and failure of statutory duty.	12	HIGH	14-Apr-2010	2-Aug-2010	1. Process created to enable assurance to be provided which includes corporate and directorate responsibilities. 2. Evidence being loaded onto Performance Accelerator for a full review in June with progress reports to IGAC. 3. Training provided for corporate owners and support provided to directorates for report writing. 4. Work with Jane Gear (Head of Corporate Affairs) to consider how best to triangulate information to assure the Trust Board that regulated activities are adequately met.	June 10: Training on the use of the Performance Accelerator is ongoing. Meetings have been arranged for all sponsors and owners of essential standards; this work is to be completed by mid July 10.			Executive Director: Caroline Becher Lead: Sarah Johnston Key Personnel: Essential standards owners, directorate CDs, GMs Matrons and CG managers. Contact: Sarah Johnston
769	Foundation Trust work plan	The Foundation Trust application has significant potential to divert Executive and Clinical Directors from achieving our ASPH organisational objectives.	10	HIGH	12-Mar-2008	10-May-2010	Provide clarity as to the process, timetable and the need for resources. Feb 10: Revised action plan to reflect the view of the PWC and SHA. Action plan details in file. (Refer to risk 894)	Feb 10: Final draft of the IBP approved by the Board in Jan 10 and submitted to the SHA.	3	LOW	Executive Directors: To be decided. Contact: To be decided.

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
768	Staff recruitment and retention. (BAF 2b)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff.	9	HIGH	12-Mar-2008	15-Aug-2010	Sept 09: New action plan: 1. Targeted recruitment to match national and international sources of supply 2. Promote key services and leadership through media campaign e.g. 'Join the Team', Make a Difference' 3. Provide high quality temporary staff to fill recruitment and retention gaps. 4. Targeted recruitment and retention plans (including new roles and ways of working) 5. Improve staff satisfaction (as a retention tool) 6. Increase appraisal coverage 7. Targeted clinical development and training programmes to address hot spots Dec 09: 1. Develop a Trust- wide Recruitment & Retention Strategy to include R & R steering group. 2. Develop an in-house overseas nursing programme (adaptation) 3. Weekly Nursing recruitment planning/monitoring meetings with Medicine, Theatres, Emergency Services and Maternity. 4. Weekly Staffing recruitment planning/monitoring meetings with Emergency Services, Anaesthetics and Paediatrics. 5. Participation with Medical Training Initiative. June 10: Nursing recruitment activity has slowed due to nurse to bed ration and bed number changes. Likely to re	Mar 10: Recruitment: Vacancy rate is 9.08%, 14.36% for nursing, up from 12.93% (Jan). Vacancy in SAU, Medical and Surgical wards, Maternity. ODPs / Anaesthetic nurse vacancy higher than average. Medical staffing in Paediatrics, Anaesthetics and Emergency. Retention: Turnover rate is 13% and stability 89%. Appraisal coverage now at 68% for previous 12 months. Nursing: Details given on paper update as to successful recruitment and future plans. Review of ward establishments has started. Details to improve nursing retention. Medical staffing recruitment details and review of work patterns described on paper copy. June 10: Overall vacancy rate up to 10.04%, nursing up to 16.23%. Nurse turnover down to 12.14%. Medical staff vacancy up to 3.7% with turnover up to 11.42%.Nursing vacancy in A&E ,SAU, some Medical and Orthopaedic wards, NICU and maternity. Appraisal coverage now 72.2% Recruitment details in paper copy. Some recruitment has continued, meeting arranged for qualifying students, ONP continues, recruiting some middles and junior grade doctors from overseas.	8	HIGH	Executive Director: Raj Bhamber Key Personnel: Kate Clarke, Cathy Dennis, Elaine Beaumont, Judy Henville, Harriet Stephens Contact: Raj Bhamber, Kate Clarke

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
815	Potentially vulnerable network resilience and/or disaster recovery for IT programmes. (BAF 4a)	The risk results from an ABSENCE in (a) Fire suppression in AH computer room (b) written Disaster Recovery and Backup procedures (c) agreed business critical systems and order of priority (d) full use of the two computer rooms (e) sufficient redundant network links between core and edge.	8	HIGH	6-Feb-2009	5-Jul-2010	1. Increase network resilience to include server virtualisation and shadowing/mirroring systems between sites (see risk 727) 2. Implement disaster recovery plan for IT-external audit review underway which will be cross referenced with Business Continuity Plans and the IT Portfolio (see risk 751) 3. Install fire suppression controls in the AH computer. room. (see risk 752) 4. Develop a robust backup strategy which will support the growth of the future development of the IT Infrastructure. 5. Document backup procedures and review on a regular basis. 6. Obtain Trust agreement on business critical systems and orders of priority. 7. Implement additional redundant network links between core and edge.(see risk 754) 8. Establish regular External/Internal Audit reviews.	Feb 10: Capital bid for fire suppression to be moved forward by Dave Axton. Disaster recovery plan nearing completion. Virtualisation project underway in March 2010. IT systems portfolio now web based and Responsibilities of System Owners and Administrators are detailed in the Information Security Policy due to be ratified by the IG Steering Group. Written DR procedures for Priority One systems underway, with several completed. Redundant network links now in place. Apr 10: 1. Plans in place for server virtualisation . 2. DR plan now developed as is IT Systems Portfolio. 3. Harold Teague (Fire advisor) now ready to order. LEP has approved expenditure. 4. Backup strategy will be developed as part of 1. 5. Written backup procedures for seven key systems have been developed, more this year. 6. All systems now have a Priority Rating on the web-based IT Systems inventory and in addition a new Priority matrix has been developed which will improve decision making. 7. Redundant links installed at AH; now getting quotes for SPH. 8. Good relationship with auditors has been developed with a			Executive Director: John Headley Manager: Robin Gammon Contact: Margaret Broomfield, Laura Ellis-Philip

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
832	Loss of income-Contracts. (BAF 3a)	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	5-Jul-2010	1. Robust review of monthly activity and income against plan. 2. Performance reports set up for BCMs. 3. Contract data challenge process largely automated now, allowing more robust counter-challenge. 4. Executive team and BCMs to be briefed on changes to the contract and actions required. Nov 09: 1. Agree full year value contract challenges (including TNRF) to give financial certainty. 2. Conduct full reconciliation of SUS and SLAM against CBSA reconciliation statement - or pursue formal mediation / reconciliation with SHA if not resolved satisfactorily. Apr 10: 1. Agree full year value for contract challenges with Surrey PCT for 2010/11. 2. Ensure Trust has clear monitoring processes in place for new DH-mandated contractual risks 2010/11 (Schedule 3, part 1) e.g. DSSA non-compliance, key performance targets, 'never events'.	Dec 09: Details for Nov now signed off. Q1 reconciliation value settled. Similar process to be followed for Q2 and month 7 reconciliation. Apr 10: Value of £1.4m agreed with Surrey PCT via Heads of Agreement April 10 against agreed list of data challenges, including LPP. Information Department reviewing internal performance dashboard to ensure organisational needs are met. Risk remains high but reduced from 12 to 8.	6	MED	Executive Director: To be Decided Lead: Sue Robertson Contact: Sue Robertson (Head of Planning and Performance)
894	Not being licensed for FT status (BAF 3b)	Not being licensed would be due to: 1. Organisational transformation 2. Lack of support from the Local Community, PCT/SHA, DH/Monitor 3. Lack of approval to proceed There is a risk of financial loss and loss of reputation.	8	HIGH	2-Sep-2009	11-Jun-2010	1. Rigorously managed project to deliver F.T 2. Robust project Plan and project management. 3. Approval of IBP final. 4. Organisational transformation program 5. Dummy FRP by EY 6. Board to Board with SHA 7. Complete action plan from PWC review Feb 10: Action Plan update provided and headed 'Report to Foundation Trust Project Board - Paper 3.0'	Feb 10: Further iteration of the IBP approved by the Board in January 2010. Action plan to deliver the work programme is maintained monthly by the FT Project Board. (Full paper copy details provided and headed 'FT Application - PWC / SHA actions Finance only') April 10: FT application now supported by the SHA and with D of H, however still await outcome. Challenge to be authorized as a FT is now more demanding. All controls in place to ensure progress.	3	LOW	Executive Director: To be decided. Lead: To be decided. Contact: To be decided.

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers namely Lodestone and Inhealth.	6	MED	26-Mar-2009	15-Oct-2010	1. Re-negotiation of contract for a 10 year period with Lodestone. 2. Negotiate a contract extension for 18 months with Inhealth. 3. Joint management boards to review quarterly.	Mar 09: Contracts have been reviewed by the Trust's legal team to ensure minimal risk financially and to limit other risks. Due diligence has been completed. July 09: 'In Health' have renewed the contract for 18 months, however there is still a chance of other factors leading to a break in the service. Risk Tolerated Mar 10: The Trust will retender for above contract in 2010. Risk returned to Treat. June 10: Finance committee has agreed to extend the contract for another 12 months whilst a full tender process is actioned.			Executive Director: Valerie Howell Contacts: Catherine Townsend
816	Failure to develop IT infrastructure appropriately. (BAF 4a)	The IT Asset Inventory is not accurate and identified owners are not routinely recorded. There is an absence of a detailed software / systems register. There are insufficient resources to develop new technologies to maximise return on investment. Competing projects demanding resources impedes progress and development of new technologies in a controlled and logical manner.	6	MED	6-Feb-2009	2-Jul-2010	1. Develop a systems register (from IT Systems Portfolio) and maintain an accurate IT Asset Inventory. 2. Upgrade/replace end of life/out of date hardware and software (partly risks 748 and 749) 3. Maximise return on investment by utilising infrastructure to full potential e.g Server Virtualisation (partly risk 727) 4. Develop Infrastructure/systems roadmap. 5. Review IT department organisation to facilitate staff resource to implement new technologies. 6. Establish regular External/Internal Audit reviews 7. Conduct NIMM assessment and review. Nov 09: 1. PAS printer replacement project established. 2. Review of IT department organisation.	Nov 09: New PAS hardware working. Internal audit programme now in place. NIMM Assessment workshop planned for 26/11/09. Mar 10: Referring to Action Plan 2. Risk 748 closed, risk 749 Printer rationalisation project 3. Virtualisation plan in place, June 10 implementation. 4. IT Roadmap developed. 5. Review completed (risk 745) changed to tolerate. 6. Completed 7. Due to take place Q1 2010. Risk reduced to Medium.			Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield
847	Under delivery of CIP programme. (BAF 4b)	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.	6	MED	20-May-2009	5-Sep-2010	1. Create a demand and capacity plan for each Surgical specialty. 2. Theatre user group to be established to oversee the operational efficiency of theatres. May 10: 3. Create a PMO office to monitor and report on CIPs for 2010/11 and future years. CIP programme board in place chaired by Deputy Chief Executive to monitor CIPs.	Nov 09: Further Theatres CIPs generated. Capacity Planning Project underway. Lean project underway. Feb 10: A number of new CIPs identified for 2009/2010 to ensure the CIP is on course to achieve its target for the year end. May 10: Risk closed for Surgery only; due to risk being realised by the end of the financial year. May 10: In March 10 CIP target achieved for 2009/10. £9 million of CIPs taken from the baseline budget and monitored through PMO office.	2	LOW	Executive Director: Valerie Howell Key personnel: Valerie Howell, Barrie Jones, Jenny Johnson, Charlotte Freeman. Contact: Barrie Jones

Corporate Risk Register as at 16th June 2010

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766	Patient satisfaction scores. (BAF 1d)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	4	MED	12-Mar-2008	4-Sep-2010	Nov 09: The Medical Director & Chief Nurse will be introducing on Nov 5th a hand held audit toll to track progress & matron influence on standards. June 2010: 1. Ten point plan kick start. 2. Outpatient action plan. 3. Programme Board for the Patient Experience. 4. Directorate plans for patient experience monitored through performance meetings. 5. Feedback strategy.	Nov 09: Chief Nurse has now completed the matron development plan and clinical Fridays were launched in October. March 10: Remains a high priority. Matrons now high profile with new uniforms and expected to be actively available to patients. Latest data being processed. June 10 1. Ratified Comms and Engagement Strategy. 2. Dashboard for patient satisfaction. 3. Ward quality indicators. 4. Comments cards. 5. Pilot for hand held device undertaken in February. 6. CQUIN Target. 7. 4 Ps Values and Behaviours. 8. Noise at night action plan. 9. Dignity Gowns.	6	MED	Executive Director: Valerie Howell, Caroline Becher Contact: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1e)	Potential failure to improve upon Privacy and Dignity issues for service users.	4	MED	12-Mar-2008	8-Aug-2010	Require strict adherence to the reduction and ultimate elimination of the acceptance of mixed sex gender accommodation for patients in all general areas and improved awareness and action to minimise the impact on patients in assessment and high intensity care arenas. Sept 09: Act to eliminate patient exposure to mixed sex accomodation	Sept 09: The remodelling programme is on track. Mar 10: All required areas should be single sex compliant by the end of March 2010. June 10: Bed remodelling continues but all areas are now virtually compliant with the delivery of single sex accomodation. Risk reduced to Medium.	4	MED	Executive Directors: Caroline Becher Contact: Sue Brown
907	Service failure-Swine Flu Pandemic	The Swine Flu Pandemic may cause a high number of staff sickness and absence and a high number of patients (adult and paediatric) requiring hospital admission and intensive care consequently there is a risk of service failure. The key issues will be: (a) Service provision and performance targets (Business continuity) (b) Suboptimal patient care (c) Staff fatigue (d) Demand and capacity (e) Ethical considerations (f) Supply chain failure At risk: Service failure; Reputation; National targets; Statutory duty	3	LOW	16-Sep-2009	4-Jul-2010	1. Local areas to have Business Continuity Plans in place. 2. Main Pandemic Flu Plan supported by local area Flu plans. 3. Local ethical framework to be developed. 4. Escalation plans to meet the demand of Winter planning, bed remodelling and swine flu admissions. Dec 09: On going day to day management and adjustments to flu plan. Impact monitored daily, in house, as well as by the PCT/SHA.	Dec 09: Patient numbers have been below the expected level. It is still unknown as to how the disease will develop. Remains high risk due to this and winter pressures. Mar 10: Experience throughout the Winter months both locally and across the UK has shown significantly lower than expected levels of infection from the Swine Flu virus. The Swine Flu Hotline is now closed and D of H statistics indicate low levels of infection and ,since Christmas, high vaccination figures for designated risk groups. The risk is at present low.	3	LOW	Executive Director: Valerie Howell Lead Manager: Valerie Howell Key Personnel: Valerie Howell Contact: Valerie Howell from Jan 10

Corporate Risk Register as at 16th June 2010

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress - late 2009 to June 2010	Rating (Target)	Risk level (Target)	Responsibility Owners
887	Loss of Person Identifiable Data	There exists the possibility of the loss of PID as a result of a lack of understanding from staff regarding personal responsibility for data and information governance (IG). At risk: Patient safety, Financial Loss, Reputation, Failure of Statutory duty.	3	LOW	17-Jul-2009	7-Jul-2010	Develop and instigate mandatory IG training that demonstrates and promotes adherence to trust policy and legislation	Nov 09: Only encrypted memory sticks are to be used in the Trust. All others have now been banned and staff have been informed by Aspire (paper and electronic) and their managers. Port control is being tested. Training is now mandatory (2 year cycle) for information governance and will be completed by the end of Jan 2010. Mar 10: Port control implemented, Information Governance training nearly completed for all staff, encrypted memory sticks available and all laptops encrypted. Risk now low.	6	MED	Executive Director: Mike Baxter Key personnel: Robin Gammon, Alex Williams Lead: Robin Gammon Contact: Alex Williams, Tracy Street
Tolerate: Accept the risk at its current level of risk											
848	Financial loss due to uninsured claims	Uninsured losses in excess of £100,000, particularly associated with claims preceding NHSLA insurance arrangements.	12	HIGH	20-May-2009	11-Jun-2010	Solicitor to undertake investigation and develop a defence case covering one particular area of risk. Claims will be managed on a case by case basis.	Dec 09: 'Defence' investigation due to commence Jan 2010. CM to liaise with the solicitor. Mar 10: Awaiting report from Facilities concerning asbestos review undertaken by outside consultancy.	9	HIGH	Executive Director: John Headley Lead: Colin Matthew, John Headley Contact: Colin Matthew
745	IT: Over reliance on key individuals with specialist knowledge.	The Trust has a small number of experienced site-based staff, who look after the infrastructure systems, only two or three of whom have a deep knowledge such as that required to recover from a major outage.	6	MED	10-Jan-2008	24-Aug-2010	1. Recruit to vacant posts. 2. Review IT department organisation structure and roles/responsibilities. 3. Identify new roles and prepare business cases and recruit. 4. Knowledge sharing across department. 5. Create and maintain robust process and procedures documents for supporting all systems. 6. Develop central register of 3rd party support details. (IT Systems Portfolio) 7. Establish regular External/Internal Audit reviews. June 08: New mitigating action is for MDA to prepare a business case for additional technical staff.	Nov 09: Internal sharing of knowledge is being managed within the department. The role of Maxwell Freer has been amended to Networks and Systems Manager. Risk now tolerated. Mar 10: No changes, the risk remains tolerated			Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield