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

TRUST BOARD
27th September 2012

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 18th September 2012. Since last reporting to the Trust Board (28th June 2012) the following is noted: • Three new risks opened • Two risks have closed
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 September 2012
Decision:	For Review

TRUST BOARD
27th September 2012

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 24th August 2012. The next meeting is 28th September 2012.

New Risks

ID	Title	Description	Opened	Current level	Responsibility Owners
1214	Data Issues (BAF 1.1)	Poor quality data, arising from numerous issues; delayed definitive diagnosis, data input and timeliness, poor quality data cleansing and validation prior to external submission leading to risks of: 1. Suboptimal clinical care, treatment and outcomes 2. False assurance 3. Failure to intervene and drive improvement 4. False indicators of poor care leading to reputational risk 5. Poor service design and delivery models	3rd July 2012	**12**	Executive Directors: David Fluck and Suzanne Rankin Lead Managers: Heather Caudle and Donna Marie Jarrett
1215	Lack of appropriate speciality bed availability to place patients in the correct clinical area, (BAF 4.1, 5.4 & 1.5)	Patients who are outliers may be at risk of not receiving specialist care from staff familiar with their presenting condition. This then creates potential for poor quality of care and experience.	18th July 2012	**8**	Executive Lead: Suzanne Rankin Lead Manager: Jenny Farley and Vanessa Avlonitis
1217	Poor clinical documentation leading to potential failure to comply with CQC Essential standard – Outcome 21:Records, (BAF 5.5)	Following the CQC inspection on 23 May the Trust was deemed non-compliant with Outcome 21: records - with potential moderate impact upon patients. Failure to address this non-compliance and improve standards of documentation may result in poorer or unsafe patient care and ultimately – if re-inspected may result in enforcement action being taken by the CQC.	3rd August 2012	**9**	Executive Lead:- Suzanne Rankin Lead Manager involved in Achieving Action Plan:- Heather Caudle

Risks Closed

ID	Title	Reason	Responsibility Owners
1128	Capacity issues affecting quality of care for patients in AE , (BAF 4.1, 5.4 & 1.5)	Merged risk with 1147 – new risk 1215	Executive Lead: Suzanne Rankin Lead Manager: Jenny Farley
1147	The use of escalation beds Trust wide compromises patient safety and dignity (BAF 3.1 & 1.2)	Merged risk with 1128 – new risk 1215	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Trust Board Summary of Corporate Risks as at 18th September 2012

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risks							
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	HIGH	12	TREAT	12 March 2008	29 October 2012	Executive Director: Suzanne Rankin Lead Manager: Linda Towey
764	Delivery on all Performance Targets. (BAF 1.3 & 4.2)	HIGH	12	TREAT	12 March 2008	30 October 2012	Executive Director: Valerie Bartlett Lead Manager: Valerie Bartlett Contact : Claire Braithwaite
1037	Failure to monitor and review compliance with CQC regulations. (BAF 1.2)	HIGH	12	TREAT	16 July 2010	22 October 2012	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle
1129	28 day readmission rate (BAF 4.2)	HIGH	12	TREAT	31 March 2011	31 October 2012	Executive Director: David Fluck
1208	Underperformance of CIP Programme for 2012/2013 and lack of a robust CIP Strategy in place for the medium to longer term. (BAF 4.4)	HIGH	12	TREAT	14 May 2012	04 October 2012	Executive Director: Valerie Bartlett Lead Manager: Mark Hinchcliffe
1217	Poor clinical documentation leading to potential failure to comply with CQC Essential standard – Outcome 21:Records	HIGH	9	TREAT	03 August 2012	22 October 2012	Executive Lead:- Suzanne Rankin Lead Manager involved in Achieving Action Plan:- Heather Caudle
1215	Lack of appropriate speciality bed availability to place patients in the correct clinical area, impacting on the quality of care delivered to patients	HIGH	8	TREAT	18 July 2012	30 October 2012	Executive Director: Suzanne Rankin Lead Managers: Vanessa Avlonitis / Jenny Farley
1214	Data Issues (BAF 1.1)	HIGH	12	TREAT	03 July 2012	30 October 2012	Executive Directors: David Fluck and Suzanne Rankin Lead Managers: Heather Caudle and Donna Marie Jarrett
832	Loss of income-Contracts. (BAF 4.8 & 4.2)	HIGH	12	TREAT	26 March 2009	03 October 2012	Executive Director: Simon Marshall Lead Manager: Stephen Hepworth
1072	Discharge process has identified risks to vulnerable patients (BAF 1.5 & 1.2)	HIGH	12	TREAT	02 September 2010	01 November 2012	Executive Director: Suzanne Rankin Lead Manager: Caroline Farrar
1130	Lack of assurance of robust adult safeguarding procedures (BAF 1.2)	MED	6	TREAT	31 March 2011	12 December 2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1057	Possible loss of patient confidence in the Complaints service. (BAF 1.2 & 1.6)	MED	6	TREAT	12 August 2010	01 November 2012	Executive Director: Suzanne Rankin Lead Manager: Sal Maughan.
766	Patient satisfaction scores. (BAF 1.2)	MED	4	TREAT	12 March 2008	08 November 2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Trust Board Summary of Corporate Risks as at 18th September 2012

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Tolerate: Accept the risk at its current level of risk							
1110	Loss of NHS income arising from damage to property.	HIGH	8	TOL	20 January 2011	28 March 2013	Executive Director: Simon Marshall Lead Manager: Miriam Moore
1113	Fraud and Corruption	MED	6	TOL	02 February 2011	18 April 2013	Executive Director: Simon Marshall Lead Manager: Miriam Moore

Corporate Risk Register
Trust Board - 27th September 2012

ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1.2 & 2.4)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions. Risk to patients and Trust reputation	12	HIGH	12/03/2008	29/10/2012	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: Action Plans have been updated to reflect the current status July 2012: Action plans have been updated. August 2012: Action plan has not been updated as remina on trajectory in regards to MRSA bacteraemia and Clostridium difficile at the end of July	**All previous updates can be accessed from paperwork held in the Quality department**. **April 2012:** The Trust trajectory is set at 1 MRSA bacteraemia for 2012-2013. This risk has been increased to high as the Trust has reported a hospital acquired MRSA bacteraemia in April 2012. Vigilance in practice is paramount and should be in line with our MRSA action plan for 2012-2013 not to exceed our trajectory. **July 2012:** Action plans have been updated to reflect the present HCAI numbers which are below the limit the limit for MRSA but above trajectory for CDiff at 6 cases year to day. Emphasis being on risk assessment and appropriate sampling. The rolling totals are reviewed on a monthly basis to map rates in regard to trajectory. **August 2012:** On trajectory **September 2012:** Remains on trajectory - 1 x MRSA and 9 x CDiff	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Towey

Corporate Risk Register
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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
764	Delivery on all Performance Targets. (BAF 5.4)	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	12/03/2008	30/10/2012	**Previous Action Plans held on paper in Quality** **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) **June 2012** - continuing to impelment the action plan - delivery remains a challenge but seen significant improvement since mid April.	**All previous progress held on paper by the Quality Department** **June 2012:** Continuing to impelment the action plan - delivery remains a challenge but seen significant improvement since mid April **August 2012:** All performance targets associated with the monitor compliance framework target were met during quarter 1 and we are currently on track for quarter 2. Maintaining the 4 hour standard for A&E waits is still a challenge and we continue to implement the action plan to fix the emergency care pathway. **September 2012:** 18 week action plan complete and sustainable delivery of target. No change to the 4 hour target from the August update.	4	MED	Executive Director: Valerie Bartlett Lead Manager: Valerie Bartlett Contact : Claire Braithwaite

Corporate Risk Register
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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1037	Failure to monitor and review compliance with CQC regulations. (BAF 1.2 & 5.5)	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	16/07/2010	22/10/2012	**All previous actions held on paper by the Quality Department** **Aug 2012:** Clinical Governance Structure reviewed new meeting structure in place from January 2013 New post in Quality Department Head of Accreditation & Regulation **Sept 2012:** On 27 July, the Trust shared its action plan with the CQC in reponse to the most recent inspection. The plan consists of 14 actions which seek to address the concerns highlighted by the CQC inspection, incuding training, support and robust monitoring of standards of clinical documentation. Each action has a test of effectiveness and progress is monitored weekly by dashboard and high level meeting and is reported by Associate Director of Quality to IGAC.	**All previous progress held on paper by the Quality Department** **August 2012:** The Trust received the final report from the CQC on the 25th July 2012. Outcomes 1, 4, 5, 8 &14 were judged to be compliant. Outcome 21 relating to documentation was found to be non-compliant and an action plan is in place. The risk has been raised as a corporate risk. There is Trust wide training on Law & Record Keeping planned for October 2012. **Sept 2012:** Action plan in place and monitored weekly, good progress is being made and all actions are on track - completion is expected by Dec 2012.	4	MED	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle
1129	28 day readmission rate (BAF 4.2)	High readmission rate indicative of poor quality. requirement to eliminate elective-emergency admissions and reduce emergency-emergency rate by 25% . Loss of funding for readmission following primary elective admission (possible for both episodes of care) to sum of circa £1.6m. Financial Impact of emergency-emergency readmissions not yet known	12	HIGH	31/03/2011	31/10/2012	**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.	**All previous progress held on paper by the Quality Department** June 2012: Still awaiting basline form PCT from which the target is calculated. It is going to be a reduction of all inappropriate readmissions which will have a financial impact. Reducing readmissions remains a quality performance indicator which is reviewed and monitored by the divisions **September 2012**: The current readmission rate has not significantly reduced. We are still awaiting the completion of the PCT audit which will determine the financial impact of readmissions.	4	MED	Executive Lead:- David Fluck

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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1208	Underperformance of CIP Programme for 2012/2013 and lack of a robust CIP Strategy in place (BAF 4.4 & 5.6)	The financial strategy of the Trust requires overall savings of £12m in 2012/2013. 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	14/05/2012	04/10/2012	**All previous actions held on paper by the Quality Department** Future CIP planning will focus on efficiency through: Internal and external benchmarking and opportunity analysis, profit / loss analysis. Redesign and improvement of services. Identification and adoption of best / evidence based practice and development of innovations. Robust Trust-wide systems of financial governance as standard. A comprehensive process of benchmarking will be established and shared across the Trust and there will be an external focus on identifying and adopting best practice and in developing the Trust's own innovations. This will help in determining and driving forward service redesign and improvements. On-going actions throughout 2012/2013	**July 2012- July 2012:** Working with CIP leads to develop project plans and milestones for delivery of PMO monitored CIPs • Working with DGMs and CIP leads to shore-up schemes that are not assured - PMO Assured total now £6.5m and high-risk schemes reduced to < 2m • Initial workshop held to develop new schemes and themes for 2012/2013 and beyond • Reporting mechanisms for CIP leads / PMO / Execs confirmed **August 2012:** Working with CIP leads to develop project plans and milestones for delivery of PMO monitored CIPs Working with DGMs and CIP leads to assure and deliver schemes for in-year CIPs - PMO Assured total now £8m and high-risk schemes reduced to < 300k Objectves set for developing new schemes and themes for 2012/2013 and beyond	4	MED	Key Personnel: Executive Director: Valerie Bartlett Key Personnel: Claire Braithwaite, Caroline Boswell Lead Manager and Updates: Mark Hinchcliffe

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1217	Poor clinical documentation leading to potential failure to comply with CQC Essential standard - Outcome 21:Records (BAF 5.5)	Following the CQC inspection on 23 May the Trust was deemed non-compliant with Outcome 21:records - with potential moderate impact upon patients. Failure to address this non-compliance and improves standards of documentation may result in poorer or unsafe patient care and ultimately - if re=-inspected may result in enforcement action being taken by the CQC.	9	HIGH	03/08/2012	22/10/2012	There is a full corporate action plan in place to treat this risk. Corporate leads have been assigned and monitoring will take place through weekly meetings. All actions are due to be completed by October 2012 and the action plan closed by March 2013 following rigorous tests of effectiveness of actions taken. **September 2012:** New risk recorded following the CQC inspection of 23 May 2012 and judgement that the Trust was not compliant with Essential Standard - Outcome 21: Records. The CQC judged non-compliance may have a moderate impact on patient care.	**August 2012** - New Risk **September 2012**: An action plan is in place and is monitored weekly and is reported by the Associate Director of Qulaity to IGAC. Good progress is being made and all actions are on track - completion is expected by Dec 2012. Nursing skills station days are ongoing, bespoke training is being arranged for October and new nursing competencies are under development. Ward sister's self declaration of checking stadards of record keeping is on track to report to Trust Board in October. The Trust had an announced visit from the CQC on the 11th September 2012 and the trust has been made compliant with Outcome	4	MED	Executive Lead (Corporate Risks Only):- Suzanne Rankin Lead Manager involved in Achieving Action Plan:- Heather Caudle/Vanessa Avlonitis Key Personnel :- Vanessa Avlonitis, Sal Maughan Contact for updates:- Vanessa Avlonitis
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	20/01/2011	28/03/2013	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.	**All previous progress held on paper by the Quality Department** **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. **April 2012:** Trust accepts ongoing risk, move to yearly update. Next update due March 2013. **July 2012:** Risk reviewed by the Finance Director and risk remains unchanged	3	LOW	Executive Director: Simon Marshall Lead Manager: Miriam Moore

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Trust Board - 27th September 2012

ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1215	Lack of appropriate speciality bed availability to place patients in the correct clinical area, (BAF 4.1, 5.4 & 1.5)	Patients who are outliers may be at risk of not receiving specialist care from staff familiar with their presenting condition. This then creates potential for poor quality of care and experience.	8	HIGH	18/07/2012	30/10/2012	Integrated Community Team based in A & E to prevent unnecessary admissions . Direct GP referrals to go straight to Medical Assessment and Surgical Assessment Units thus avoiding A & E and unnecessary delays. Implementation of See and Treat, Rapid Assessment (&) Treatment in A & E , implementation of Ambulatory Care Pathways in A & E to prevent unnecessary admissions. Implementation of Medical and Surgical Non Elective Care Pathways. Patients directed via the bed management teams to the correct ward only and no outliers. Appropriate escalation policies to minimise patients waiting in A & E for longer than 4 hours. Bed Capacity Model to be implemented by 30 September. **August 2012:** Aciton plan remains the same	September 2012: Implementation of phase 1 of the new Emergency Care Pathway and model will support the allocation of patients to the correct speciality bed. As part of winter planning the approach to provide speciality review 24/7 will be refreshed.	4	MED	Executive Lead: Suzanne Rankin Key Personnel: Jenny Farley and Vanessa Avlonitis Contact for Updates: Jenny Farley
1214	Data Issues (BAF 1.1)	Poor quality data, arising from numerous issues; delayed definitive diagnosis, data input and timeliness, poor quality data cleansing and validation prior to external submission leading to risks of: 1. Suboptimal clinical care, treatment and outcomes 2. False assurance 3. Failure to intervene and drive improvement 4. False indicators of poor care leading to reputational risk 5. Poor service design and delivery models	12	HIGH	03/07/2012	30/10/2012	Mortality Project meeting in October to scope further issues Address concerns after monthly reviews of dashboards. Manual supliers will activate systems following the Project Board.	Sept 2012: Improving data quality and coding. NHS number valadation agreed target of 98% with the PCT.	4	MED	Executive Owners: David Fluck and Suzanne Rankin Leads: Heather Caudle and Donna Marie Jarrett Contact for Updates: Donna Marie Jarrett

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832	Loss of income- Contracts. (BAF 4.2 & 4.8)	There is a reduction of contract income related to DH-mandated readmissions penalties, and potential financial penalties for non-achievement of key performance targets, plus additional local contract penalties.	12	HIGH	26/03/2009	03/10/2012	**Previous Action Plan held on paper in the Quality department.** **July 2012:** Re-admission audit underway. Action plan to be developed. **August 2012:** The action plan remains the same. The current actions include agreeing to New to Follow up rates with the PCT, agreeing the CQUIN baselines, agreeing the final four quality objectives. Further correspondance has been undertaken to remind the PCT that they are responsible for paying for overperformance within the contract. The Trust has undertaken all it obligations to ensure payments.	**All previous progress held on paper in the Quality department** ***2012-2013:*** *The Trust has agreed an income target with North Surrey that is in line with its expenditure budget. Actions to manage the target have been allocated to the Divisions. A detailed plan is being prepared to manage contract risks and activitiy targets.* **July 2012:** - Working with CIP leads to develop project plans and milestones for delivery of PMO monitored CIPs - Working with DGMs and CIP leads to shore-up schemes that are not assured - PMO Assured total now £4m - 'Closing the gap' by working with DGMs and CIP leads to identify new schemes for 2012/2013 - Confirm reporting mechanisms for CIP leads / PMO / Execs **August 2012:** The procedures to refute data challenges has been used for months one and two data changes from the PCT. This has worked well, with the majority of the data challenges being rejected or greatly reduced in value.	6	MED	Executive Director: Simon Marshall Lead Manager: Stephen Hepworth

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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1072	Discharge process has identified risks to vulnerable patients (BAF 1.2 & 1.5)	Cause for concerns relating to poor discharge planning Discharge themes identified through complaints and PALS analysis	12	HIGH	02/09/2010	01/11/2012	**Feb 12:** Managed through the Project Management Office **August 2012:** Discharge project being re-scoped with ward-based improvement programme suported by 2020 Delivery starting at the end of August, based on the successful pilot on Holly and Cedar. Weekly delays meetings chaired by the Chief Nurse start end of August. Further HNA training for Band 5 and 6 ward nurses planned for September	**All previous progress held on paper by the Quality Department** **June 2012:** HNA training for Band 7 and Matrons completed although following hands on work some require signing off. The training has produced improved HNA's. Funding is being sought to support this training. Holly and Cedar wards have got 20/20 assessment which is ongoing. **August 2012:** HNA training for ward managers and matrons completed; quality and delays to HNA's on wards have shown some improvement. **September 2012: 'Ready to go Days'** programe commenced. 1. Weekly Ready To Go Meetings chaired by the Chief Nurse with Ward Sisters, to review five longest/vunerable patient stayers to assesss their needs to expedite discharge. 2. Project plan approved by the Stragic Delivery Board. 3. Roll out commences on the 1st October on Kingfisher, Swan and Falcon Wards.	3	LOW	Executive Lead: Suzanne Rankin Lead Manager: Caroline Farrar cc Claire O'Brien

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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1130	Lack of assurance of robust adult safeguarding procedures (BAF 1.2)	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.	6	MED	31/03/2011	12/12/2012	**March 11:** Review in detail adult safeguarding concerns and processess and establish an action plan to deliver improvements. **May 11:** Heads of Nursing now taking the lead for delivery of operational safeguarding policy, procedures and practice within Divisions. First action to be Divisional Review with assessment and improvement 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 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	**All previous progress held on paper by the Quality Department** **September 2012**: Audit undertaken by Parklands on Safeguarding. Awaiting results. All training for safeguarding now incorporates MCA/DoLS/Prevent. Level one training is done for induction, level two for others. Meeting held with Adult Services each week for an update. Strategy meetings and case conferences attended by Adult Safeguarding Lead. First safeguarding meeting held recently next one on 18th September. This is used as a medium for sharing learning from safeguarding alerts etc. MAPPA training to be attended by Adult Safeguarding Lead. Attendance at the Adults Safeguarding Board and the local safeguarding group to do actions and bring them back into the trust. The first few cases of DoLS applications received details been sent to relevanct person for CQC notification. The Safeguarding/Prevent Policy, Discharge Policy and the MCA and DoLS policies are being updated.	3	LOW	Lead Manager: Suzanne Rankin Key Personnel :- Vanessa Avlonitis Deputy & Susan Brown Contact for updates:- Vanessa Avlonitis/Carrie James

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ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
1057	Possible loss of patient confidence in the Complaints service. (BAF 1.2 & 1.6)	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	12/08/2010	01/11/2012	**All previous actions held on paper by the Quality Department** 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. **Feb 12:** Improvement plan implemented in December 2011 and actions are still ongoing. **July 2012:** The Complaints Monitoring Group meeting re-arranged (14.08.12).	**All previous progress held on paper by the Quality Department** **May 2012:** Risk and action plan to treat were discussed at the Complaints Monitoring Group on 4 May. It was agreed that whilst improvements in the complaints handlimg process were evident, a sustained improvement could not be guaratneed. The group agreed the risk should remain as it is and be reviewed at the next Complaints Monitoring Group meeting on 25 July 2012. **July 2012:** An audit of complaints processes and procedures has been undertaken by the Trust internal auditors. The outcome and recommendations of this will be considered and the action plan updated accordingly. The risk remain as it is pending the outcome of the review.	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Lynn Robinson.

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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	6	MED	02/02/2011	18/04/2013	1. The Trust engages a Local Counter Fraud Specialist (LCFS) to assess the level of fraud and corruption the Trust faces. There is an annual work plan in place for the LCFS which is determined in conjunction with the Head of Internal Audit and the Director of Finance. 2. All new staff attend an induction programme which includes a fraud awareness session lead by the LCFS. There is a Fraud Management Policy and a Whistle-blowing Policy in place. Proactive exercises to test for this risk in vital or high- risk areas. **Jan 12:** In view of the level of proactive work contained within the current LCFS work plan agreed by the Audit Committee in March 2011, the risk score has been reviewed and reduced accordingly. The Audit Committee receive quarterly updates on progress with the LCFS work plan. The LCFS contract status is currently under review prior to retender.	**All previous progress held on paper by the Quality Department** **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 **Jan 12:** No change **July 2012:** Reviewed by Finance Directior - no change.	3	LOW	Executive Director: Simon Marshall Lead Manager: Miriam Moore

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Trust Board - 27th September 2012

ID	Title	Description	Rating (current)	Risk level	Opened	Review date	Synopsis (Action Plan)	Progress of Action Plan)	Rating (Target)	Risk level (Target)	Resonsibility Owners
766	Patient satisfaction scores. (BAF 1.2)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	6	MED	12/03/2008	08/11/2012	**Previous Action Plan held by the Quality Department** **Feb 12:** Actions include: further survey on February 2012 inpatients to understand whether any change in position; raising staff awareness; the Living Our Values programme has now covered large number of staff and continues engage with staff. **May 2012:** Action plan developed to address inpatient and outpatient surveys 2011. Inpatient spotlight survey underway results expected end of May to be followed by deep dive in June ahead of July 2012 inpatient survey sampling. Furtehr improving patient experience project to be defined and embedding of Living our Values programme continues	**All previous progress held on paper by the Quality Department** **Feb 12:** Preliminary results from Picker indicate that our inpatient results for July 2011 have not improved and have worsened. We are awaiting the CQC benchmarked results due around May. Results for Outpatients and A&E spotlight surveys indicate some improvements. **May 2012:** Benchmarked CQC results published on 24 April indicate that our inpatient results 2011 have improved with more scores in averge (About the same) banding. A&E Spotlight survey also indicates some improvement. National A&E Survey underway at present. **August 2012:** The 2012 Inpatient spotlights survey results have been received and show an incremental improvement in patient satisfaction. An application to the NHS Institute Patient Feedback Challenge has been successful. This will enable support to a stream of work aimed at using patient feedback, including satisfaction scores to improve patient experience.	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Sal Maughan