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

TRUST BOARD
28th April 2011

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 15th April 2011, and highlights that since 9th February 2011: • **One new risk** has been added • Two risk are awaiting Trust Executive Committee approval • Four existing risks where the risk level has changed • Zero risks with a change to the treatment plan • Three risks have been closed 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, Clinical Risk Manager On behalf of, Suzanne Rankin, Chief Nurse
Date:	15th April 2011
Decision:	For Note

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
28th April 2011

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 25th March 2011. The next meeting is 6th May 2011.

New Risk added since 9th February 2011

ID	Title	Description	Present Objective	Risk level	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.	TREAT	HIGH	Lead Manager: Valerie Bartlett Key Personnel: Wendy Pulling , Vijay Gautam & Charlotte Freeman

Risks awaiting Trust Executive Committee Approval

Title	Division	Risk Type	Source	Description	Action Plan	Principal objectives	Rating	Responsibility Owners
30 day readmission rate		CORP	FINANCIAL PRESSURES	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.	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.	TREAT	HIGH 12	Lead Manager: Mike Baxter Contact: Sarah Johnston
Lack of assurance of robust adult safeguarding procedures	NUR	CORP	COMMITTEE RISK	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.	March 11: Review in detail adult safeguarding concerns and processes 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.	TREAT	HIGH 12	Lead Manager: Suzanne Rankin Key Personnel : Vanessa Avlonitis & Susan Brown

Existing Risks where the risk level has changed since 9th February 2011

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
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.	*Previous updates held on paper in the Quality department.* Feb 11: 60% of policies are in date. The nursing action plan requires review of timescales to provide a robust plan to up date the policies that can be delivered. Other out of date policies have been fed back to the Heads of Service for action. Severity reduced to 3 but risk remains high. **March 11: Majority of policies in date with planned dates for completion for those still overdue. The exception is nursing and an action plan is in place to review this large group of polices which is being worked through during April - June at NMC.**	HIGH 9	MED 6	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
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.	Feb 11: The current evidence is being reviewed by the Trusts internal auditors in order to confirm compliance or identify any gaps relating to the 22 key requirements of the assessment. if there is any time, all the other requirements will be reviewed, however Monitor is currently only concerned with Foundation Trusts achieving a Level 2 score on the 22 Key requirements. Final assessment scores are being reviewed by the IG Steering Group on the 17th March 2011 and finalised by the Steering Group on the 24th March 2011 prior to the final submission on the 31st March 2011. **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.**	HIGH 12	HIGH 8	Executive Director: John Headley Lead manager: Jane White

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	*All previous updates can be accessed from paperwork held in 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 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 .**	HIGH 12	MED 6	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
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	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.**	HIGH 8	HIGH 12	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis cc Claire O'Brien

Risk with a changed treatment plan since 9th February 2011

None

Risk closed since 9th February 2011

1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	There are currently 27 patients who are medically fit to leave hospital within The Trust but are delayed in an acute bed waiting for either an assessment, outcome of assessment or placement by The NHS Funded Healthcare Team. This unusually large amount of delayed discharges is now having a big impact on capacity within The Trust. This number increases every day. This morning 4 more patients will be added to this number. The impact of the above number means that The Trust's ability to maintain capacity flow, 4 hour waits & 18 week targets are very much reduced. The NHS Funded healthcare team have been asked by Claire O'Brien whether they would be prepared to second one of their nurse assessors to work at ASPH for 6 months to assist the Senior Discharge Co-coordinator to train ward staff to undertake some of the assessments. The NHS funded Healthcare team has confirmed it is not possible to release one of their nurse assessors as they have a back log of assessments to carry out in the community and do not have sufficient staff to support this. Risk to patients, service, finances, not meeting targets and Trust reputation.	HIGH	31-Aug-2010	4-Mar-2011	Jan 10: Await confirmation for additional resource. There will be an on-going back log until staff are recruited and appropriately trained. Risk returned to High and Treat. **March 11: RISK TERMINATED. All acute Trusts are now expected to carry-out their own assessments which we are doing; albeit the impact has caused delays in the system.**

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 (25/02/10) the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	LOW	25-Feb-2010	18-Feb-2011	*Previous progress held on paper by the Quality Department.* Nov 10: Trust now compliant at 90%. SHA has identified ASPH as an exemplar site. RCA for all admissions with PE and DUT now in place. Monthly audits of VTE assessment quality with PE and DUT now in place. Monthly audits of VTE assessment quality to be commenced December 2010. Risk reduced from medium to low. **Feb 11: Trust now has a fully automated system of reporting and are delivering above the target values. This is an embedded system with global organisation acceptance. Compliance will continue to be monitored at divisional and Board level. RISK CLOSED.**
769	Disproportionate focus on post Foundation Trust authorisation tasks.	The Foundation Trust application has significant potential to divert Executive and Clinical Directors from achieving our ASPH organisational objectives.	MED	12-Mar-2008	3-Mar-2011	*Previous progress held on paper by the Quality Department.* Nov 10: The risk has changed to 'Disproportionate focus on post FT authorisation tasks'. The risk will be managed by identified resources in the dedicated membership office and the Communications Team to plan and implement post authorisation tasks. **March 11: RISK CLOSED as the Trust has now achieved Foundation Trust status. Working in the FT environment is now a matter of routine.**

Summary of Corporate Risks as at 15th April 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	10-May-2011	Executive Director: Valerie Bartlett Lead Manager: Valerie Bartlett
832	Loss of income-Contracts. (BAF 3.4)	HIGH	12	TREAT	26-Mar-2009	19-May-2011	Executive Director: John Headley Lead Manager: Sue Robertson
1024	Loss of income due to application of 'non elective cap'	HIGH	12	TREAT	23-Jun-2010	30-Apr-2011	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
1072	Discharge process has identified risks to vulnerable patients	HIGH	12	TREAT	2-Sep-2010	30-Apr-2011	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1128	Capacity issues affecting quality of care for patients in AE	HIGH	12	TREAT	31-Mar-2011	12-May-2011	Executive Lead: Charlotte Freeman Key Personnel: - Wendy Pulling and V Gautam
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	HIGH	12	TREAT	2-Feb-2011	1-Jun-2011	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.
1113	Fraud and Corruption	HIGH	10	TREAT	2-Feb-2011	13-May-2011	Executive Director: John Headley Lead Manager: Miriam Moore
1088	Possible non-compliance with IG Toolkit submission and achievement of Level 2 on all requirements	HIGH	8	TREAT	12-Oct-2010	9-Jun-2011	Executive Director: John Headley Lead manager: Tracy Street
1089	Lack of outpatients receptionist staff in the Trust.	MED	6	TREAT	12-Oct-2010	2-May-2011	Executive Director: Valerie Bartlett Lead manager: Hannah Donoghue
1083	Corporate lack of Trust Social Services worker post	MED	6	TREAT	21-Sep-2010	2-Jul-2011	Executive Director: Suzanne Rankin Contact: Jacqui Rees
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	13-May-2011	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	3-Jun-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	2-May-2011	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	MED	6	TREAT	12-Mar-2008	1-Oct-2011	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
768	Staff recruitment and retention. (BAF 2.2)	MED	6	TREAT	12-Mar-2008	2-May-2011	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber

Summary of Corporate Risks as at 15th April 2011

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	MED	6	TREAT	27-Oct-2008	13-May-2011	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
837	Delay in Psychiatric assessment - A & E and MAU	MED	6	TREAT	9-Apr-2009	10-Jun-2011	Executive Director: Valerie Bartlett Lead Manager: Laura Stannard
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	2-May-2011	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1.8)	LOW	3	TREAT	12-Mar-2008	2-May-2011	Executive Directors: Suzanne Rankin Lead Manager: Vanessa Avlonitis
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	1-May-2011	Executive Director: John Headley Lead Manager: Miriam Moore
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	MED	4	TOL	20-May-2009	2-Jun-2011	Executive Director: John Headley Lead Manager: Rob Jeffries

Corporate Risk Register as at 15th April 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											
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target.	12	HIGH	12-Mar-2008	10-May-2011	*All previous updates held on paper by the Quality department.* Dec 10: Increased focus on all aspects of patient flow, discharge and management of the front door to ensure good and safe flow of patients through the system and to maintain key operational targets, particularly A and E four hour wait. **Feb 11:Action plan being amended to provide additional lists as needed to meet 18 weeks.**	*All previous updates held on paper by the Quality department.* **Feb 11:For 10/11 both 90% and 4 hr standard should be achieved. The challenge is to balance elective activity against emergency demand, work is underway to validate elective activity booked and ensure lists are managed so that this target is achieved, this will require significant attention and extra activity to be booked between now and the end of March. The specialties concerned are Surgery and Ophthalmology. ASPH will achieve the 95% 4 hour standard as required by Monitor when all 4 hour performances are aggregated. For both targets forensic attention to detail will be required to ensure there is not slippage.** **March 11: No change**	4	MED	Executive Director: Valerie Bartlett Contact: Karen Lillington

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
832	Loss of income-Contracts. (BAF 3.4)	There is a loss of income related to DH-mandated financial penalties, for non-achievement of key performance targets, including single-sex accomodation. March 2011 - negotiate terms of new 2011/12 contract. Fast Steady Stop task group set up. Action plan monitored.	12	HIGH	26-Mar-2009	19-May-2011	*Previous Action Plan/s held on paper in the Quality department.* Nov 10: Report being developed with Information dept to assist Divisions in auditing any potential LPP activity. **Jan 11: Action Plan as before plus additional work on AD Operations and Deputy Chief Nurse to assure compliance with single sex accomodation requirements.**	*All previous updates held on paper by the Quality department.* Feb 11: Action plan remains as before, but with additional focus on avoiding mixed sex accommodation of patients - as a quality of care, reputation and financial risk. Year end deal agreed with NHS Surrey; formal sign off from PCT Finance Director is now outstanding. Challenges from other PCTs also being received. **March 11: New Trust declaration re MSA - financial risk of any non-compliance continues in 11/12.** **FSS actions in place for prior authorisation. Additional work continuing to capture all consultant to consultant referrals.**	6	MED	Executive Director: John Headley Lead Manager: Sue Robertson
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.	12	HIGH	23-Jun-2010	30-Apr-2011	Action plans are in place to manage non elective admissions. These are being overseen by Programme 2 'Improving service productivity and quality' Dec 10: Action plan being reviewed and updated as we monitor the impact of Winter on our performance. Refer to progress for the latest aspects of this.	*All previous updates held on paper by the Quality department.* Feb 10: 1.Wider engagement with Primary community partners through NW Transformation Board Project group 1 resulting in stronger support for implementation of ambulatory care pathways. 2. Meet and Greet pilot in A&E to support redirection of patients to alternatives to A&E due to start Feb 2011. **March 11: Work being taken forward as part of newly formed PMO.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington

Corporate Risk Register as at 15th April 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	30-Apr-2011	*Previous Action Plan/s held on paper in the Quality department.* March 11: New approach through a project managed method. Chief Nurse chairs the Steering Group for Discharge	*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.**	3	LOW	Executive Lead: Suzanne Rankin Lead Manager: Vanessa Avlonitis cc Claire O'Brien

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1128	Capacity issues affecting quality of care for patients in AE	Due to lack of capacity and patient flow some patients are waiting for prolonged periods in the A&E department whilst the department continues to receive patients from the community. The department is unable to work efficiently to meet the many and varied needs of large numbers of patients. The quality of care and treatment provided at these times is therefore at risk of degradation.	12	HIGH	31-Mar-2011	12-May-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.**		3	LOW	Lead Manager involved in Achieving Action Plan: Charlotte Freeman Key Personnel: Wendy Pulling and Vijay Gautam

Corporate Risk Register as at 15th April 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	12	HIGH	2-Feb-2011	1-Jun-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 the Friday the 6th May 2011.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.

Corporate Risk Register as at 15th April 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	13-May-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.	**April 11: The Annual Fraud Risk Assessment tool which follows the template issued by the NHS Counter Fraud and Security Management Service (CFSMS) was completed on 10 March 2011 and reported to the Audit Committee on 23 March 2011. The resulting report finds that the Trust has achieved an overall green outcome, which demonstrates a robust counter fraud arrangement. There is also work underway on revising the Whistle Blowing Policy and also the Fraud Communications Strategy in line with weaknesses identified by the CFSMS in their 2009/10 Qualitative Report. Other action points identified in this report are either implemented or underway and have been fully reported to the Audit Committee.**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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.	8	HIGH	12-Oct-2010	9-Jun-2011	Action plan currently being drawn up by IG manager in order to identify gaps and to nominate leads on each requirement Nov 10: Awareness sessions to be run where requested by departments Briefing paper to be prepared for all staff on mandatory IG training. Jan 11: IG Manager and IT Trainers working together to assist staff in completing the online training. Particular work being carried out with staff where English is not their first language in order to benchmark results. **April 11: External trainers to be brought into the Trust in May/June 2011 with a view to meeting the June 30th IG extended deadline regarding 95% of staff being trained on IG.**	*All previous updates held on paper by the Quality department.* Feb 11: The current evidence is being reviewed by the Trusts internal auditors in order to confirm compliance or identify any gaps relating to the 22 key requirements of the assessment. if there is any time, all the other requirements will be reviewed, however Monitor is currently only concerned with Foundation Trusts achieving a Level 2 score on the 22 Key requirements. Final assessment scores are being reviewed by the IG Steering Group on the 17th March 2011 and finalised by the Steering Group on the 24th March 2011 prior to the final submission on the 31st March 2011. **April 11: Level 2 compliant in 22 key requirements achieved, but with the proviso that we meet 30th June deadline regarding 95% of staff on IG Training LEP.**	3	LOW	Executive Director: John Headley Lead manager: Jane White

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1089	Lack of outpatients receptionist staff in the Trust.	This is a Risk to: compliance with PbyR and RTT data quality standards,the Trust's reputation as a result of a poor outcome of Picker Outpatient Survey Report, increased staff sickness levels, continued reliance on Bank and Agency staff. Current established staffing is at a ratio of 250-290 patients per receptionist (depending on site and week day). In addition, no uplift is in place to allow for sickness or annual leave, leaving remaining staff carrying an additional burden of patients to process through outpatient reception. Recommended staffing ratios should be around 70-100 patients per receptionist. More detail is shown in the original paper copy of the Notification Form.	6	MED	12-Oct-2010	2-May-2011	*All previous updates held on paper by the Quality department.* **Feb 11: Outpatient Efficiency Workstream being led by B Jones - will identify efficiencies to outpatient flow and areas for improvement to free up existing staff. Whilst workstream in progress, minimal agency/Bank being used to cover on ad-hoc basis. Merge of Front of House Reception and Outpatient Reception now completed - training of FoH staff being undertaken to ensure cross cover is available. Electronic self-check-in service to free up Reception staff will form part of efficiency workstream. 2 vacancies will be back filled with staff working on a flexible basis across both sites to enable greater flexibility. Existing staff now trained to enable them to flex across different sites and specialties.**	Nov 10: Sickness Capability management of two full time staff currently on long term sick: Occupational Health referrals completed. Keep in touch meetings planned for w/b 29.11.10. **Feb 11: Action plan improved (please see above). Risk score now reduced to Medium as a result of action plan.**	3	LOW	Executive Director: Valerie Howell Lead manager: Hannah Donoghue (Patient Access)

Corporate Risk Register as at 15th April 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	Currently there is no designated social services worker to lead on safeguarding children by the local authority. The risk is that vulnerable children could be missed or become unsupported by the lack of continuity of a designated social worker identified for the Trust. This risk applies to wherever children are cared for within the Trust, specifically Paediatric A&E, Paediatric wards and Paediatric Outpatients. Risk to patients, service,reputation and failure of statutory duty.	6	MED	21-Sep-2010	2-Jul-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* Jan 11: Continue ongoing monitoring of the situation ie low threshold for reporting of adverse incident which occur as a result of the lack of SW. **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.**	3	LOW	Executive Director: Suzanne Rankin Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby Contact: Jacqui Rees

Corporate Risk Register as at 15th April 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	13-May-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: Review of standards continues under current process , gaps being identified, QRP process in place, to keep risk in place for review by IGAC in February and April to ensure embedding of current process. Committees approach needs to be evidenced to provide assurance of action against CQC. **March 11: QRP indicates no red or amber risks for the Trust form CQC perspective. standards have been reallocated and progress to ensure all evidence loaded and robust regular review is ongoing;quarter 4 reviews should enable risk to be lowered or eliminated.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston
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	3-Jun-2011	1. Resource library on T drive including guidance notes and 'top tips'. 2. Clarity of expectation and performance standards with associated monitoring (via Customer Affairs and Performance meetings). 3. Training with Directorates as required. 4. Continued process of qualitative assurance. (Complaints Manger, Head of Customer Affairs, Chief Nurse). 5. Complaints Office support within Divisions. 6. Ongoing discussion with General Managers re implementation. **Nov 10: Review at the next CMG meeting in February 2010.**	Nov 10: The risk and action plan were fully discussed at the Complaints Monitoring Group on 5 Nov where it was agreed the risk remain unchanged. The action plan will be monitored and reviewed at the next meeting on 4 February 2011. **Feb 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 4 February 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 6 May 2011.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down cc Sal Maughan.

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	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 Alliance and Inhealth.	6	MED	26-Mar-2009	2-May-2011	1. Re-negotiation of contract for a 10 year period with Alliance. 2. Negotiate a contract extension for 18 months with Inhealth. 3. Joint management boards to review quarterly.	*All previous updates held on paper by the Quality department.* Dec 10: Undergoing a review of the action plan and progress with new lead manager (KL). **Feb 11: Private service provided by InHealth put out to tender January 2011. Timescales fall within plan to ensure continuity of service and manage risk of loss of provider.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Karen Lillington
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	1-Oct-2011	*All previous action plans can be accessed from paperwork held in the Quality department.* Aug 10: Trust wide MRSA action plan updated 9th August and local blood culture action plan formulated following the five MRSA bacteraemias Root Cause Analysis. Details held with paper copy update. Jan 11: Action Plan updated December 2010. to reflect that all the actions remain ongoing **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 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 .**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
768	Staff recruitment and retention. (BAF 2.2)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff resulting in a risk of inadequate staffing with a consequent impact on the quality of patient care.	6	MED	12-Mar-2008	2-May-2011	*All previous updates held on paper by the Quality department.* Feb 11: (update of Dec 10 plan) - 1. Continued implementation of Nursing R&R Strategy/action plan includes rolling, generic recruitment for band 5 nurses. 2. Continuation of ONP course, ending in February (18 participants). 3. Implementation of nursing workforce review to inform future recruitment plans 4. Recruitment of A&E doctors & implementation of new middle grade A&E rota. 5. Reduction in Midwifery vacancy rate since August continues to be supported through dedicated action plan which has resulted in all current vacancies being filled through actual and prospective new starters	*All previous updates held on paper by the Quality department.* **Feb 11: 1. Sustained downward trend in nurse vacancies (qualified vacancies down from 16.2% in April to 10.3% in December. Net qualified Nurse & Midwife headcount has increased by 45 since April. 13 new Band 5 staff nurses being processed for medical wards plus 14 for other areas.** **2. ONP course commenced in September. 18 nurses on track to register with NMC in Feb and transfer into band 5 posts.** **3. 1 A&E Consultant to commence 14 March 2011. Bank Consultant started February 2011. Further advertisements for Consultant and middle grade positions open - interviews 5th March 2011. Enhanced bank rates agreed until end of March to mitigate agency expenditure. Risk reduced to medium.**	4	MED	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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.	6	MED	27-Oct-2008	13-May-2011	*All previous updates held on paper by the Quality department.* Feb 11: In discussion with CCG, the Heads of Service will be provided with a list of all policies and take responsibility for those within their team. Reminders will be sent. The Quality department will link with Heads of Service for performance management and policy owners for support. Nursing action plan timescale are being reviewed. **March 11: Majority of policies in date with nursing and patient care policies being reviewed over April - June in. Action plan changed to reflect improving process for continuous review - policy has been updated, polices due for renewal will betaken to CCG to inform Heads of service and departments for action 3 months prior to review date.**	*All previous updates held on paper by the Quality department.* Feb 11: 60% of policies are in date. The nursing action plan requires review of timescales to provide a robust plan to up date the policies that can be delivered. Other out of date policies have been fed back to the Heads of Service for action. Severity reduced to 3 but risk remains high. **March 11: Majority of policies in date with planned dates for completion for those still overdue. The exception is nursing and an action plan is in place to review this large group of polices which is being worked through during April - June through NMC.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Sarah Johnston

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
837	Delay in Psychiatric assessment - A & E and MAU	Due to a change in the service the home treatment team (HTT) provide assessment of psychiatric referrals in A & E. The current service has been placed at a lower priority . There is restricted out of hours service. This results in delays in acute psychiatric assessments. At risk: Patients, staff and service. (4hr target)	6	MED	9-Apr-2009	10-Jun-2011	Aug 10: 1. Develop one-page overview of which psychiatric services to contact under what circumstances - Nasreen Moosafur, 31 August (Lead, Liaison Psychiatric Team) 2. Write-up issues arising related to psychiatric patients in the A&E and email to Lucy O'Meara - A&E, ongoing (6+ forms have submitted to date) 3. Implement monthly Local Mental Health Interface meetings - Nasreen Moosafur, Kate Lawrence, Wendy Daniels (complete - first meeting scheduled for 9 September) 4. Increase the number of psychiatric nurses as part of the Liaison Psychiatry team from 1 to 3 and increase cover from 5 pm up until 8 pm - Lucy O'Meara, 31 July (delayed due to consultation process) 5. Consider commissioning of 3 PAs per week of Consultant Psychiatric time - Claire O'Brien/Pat Rubin 6. Develop joint care plans for top re-attenders to A&E - Nasreen Moosafur & Wendy Daniels, 30 Sept and ongoing 7. Develop a joint agenda for improving care of patients presenting at A&E with psychiatric issues - Nasreen Moosafur, Wendy Daniels and Laura Stannard.	*All previous updates held on paper by the Quality department.* Nov 10: Monthly Interface meetings now in place - Kate Lawrence's name to be replaced by Charlotte Freeman. Claire O'Brien has commissioned additional psychiatric assessments of Consultant time from 1st Dec. Additional meeting to be held with A&E and Brian Parsons to agree way forward on 17th November. **March 11: Psychaitric liaison increased from 08.00 - 20.00** **Interface meetings between Psychiatric services and A&E staff contiuing** **Psychiatric liaison team being given space in the A&E department to work which further improves working relations.**	2	LOW	Executive Director: Valerie Bartlett Lead Manager: Laura Stannard Contact: Laura Stannard

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
766	Patient satisfaction scores. (BAF 1.7)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	4	MED	12-Mar-2008	2-May-2011	*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.* 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. 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.**	6	MED	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down
767	Privacy and Dignity issues for service users. (BAF 1.8)	Potential failure to improve upon Privacy and Dignity issues for service users resulting in possible patient anxiety and risk to Trust reputation	3	LOW	12-Mar-2008	2-May-2011	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. Aug 10: Refurbishment ongoing. **Nov 10: Needs to be kept on the risk register due to capacity pressures although currently compliant and refurbishment almost complete.**	*All previous updates held on paper by the Quality department.* Aug 10: Peer review very positive. No single sex breaches apart from Clinical need. Work continues to ensure compliance with the single sex accomodation agenda. Risk reduced from Medium to Low. **Nov 2010: No change except that Kestral has opened. Plans to address Privacy and Dignity for the older person in January 2011.**	2	LOW	Executive Directors: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Corporate Risk Register as at 15th April 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	1-May-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.	March 2011: No change	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 15th April 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	4	MED	20-May-2009	2-Jun-2011	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. **Aug 10: Revaluation of all existing schemes. Increased governance arrangements around all schemes. Weekly update to CEO. Weekly update on schemes progress by General Managers. Re-launch of CIP programme. Additional schemes identified.**	*All previous updates held on paper by the Quality department.* Nov 10: Instigation of CIP sign off meetings at Month close. Development of risks and opportunities schedule. Risk score lowered from 12 to 8 but remains a high risk. **Feb 11: Risk of major failure of CIP programme for 2010/2011 now reduced to Medium and Tolerated**	2	LOW	Executive Director: John Headley Lead Manager: Rob Jeffries