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

TRUST BOARD
29th March 2012

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 15th March 2012. Since last reporting to the Trust Board (18th Jan 2012) there have been no risks opened or closed. Target Risk Scores have been reviewed and updated by the Risk owners.
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:	15th March 2012
Decision:	For Review

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
29th March 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 February 2012. The next meeting is 23rd March.

Summary of Corporate Risks as at 15th March 2012

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risks							
1150	Underperformance of CIP Programme in 2011/12	HIGH	15	TREAT	29-Jun-2011	15-Apr-2012	Executive Director: John Headley Key Personnel : Valerie Bartlett; Paul Gilmore and Mark Hinchcliffe
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	HIGH	12	TREAT	12-Mar-2008	18-Apr-2012	Executive Director: Valerie Bartlett Lead Manager: Claire Braithwaite
832	Loss of income-Contracts. (BAF 3.4)	HIGH	8	TREAT	26-Mar-2009	14-Apr-2012	Executive Director: John Headley Lead Manager: Stephen Hepworth
1072	Discharge process has identified risks to vulnerable patients	HIGH	12	TREAT	2-Sep-2010	28-Mar-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1128	Capacity issues affecting quality of care for patients in AE	HIGH	12	TREAT	31-Mar-2011	27-Apr-2012	Lead Manager: Steve Crouch Key Personnel: Marcus Wootten
1129	28 day readmission rate	HIGH	12	TREAT	31-Mar-2011	28-Mar-2012	Lead Manager: David Fluck
1130	Lack of assurance of robust adult safeguarding procedures	HIGH	9	TREAT	31-Mar-2011	2-May-2012	Executive Director: Suzanne Rankin Key Personnel :Vanessa Avlonitis & Susan Sexton
1037	Failure to monitor and review compliance with CQC regulations.	HIGH	12	TREAT	16-Jul-2010	18-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Heather Caudle
1147	The use of escalation beds Trust-wide compromises patient safety, privacy and dignity.	HIGH	9	TREAT	12-Jun-2011	2-May-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	MED	6	TREAT	2-Feb-2011	18-Mar-2012	Executive Director: Suzanne Rankin Lead Manager: David Fluck
1083	Corporate lack of Trust Social Services worker post for Paediatric services	MED	6	TREAT	21-Sep-2010	11-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Jacqui Rees
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	8-May-2012	Executive Director: Suzanne Rankin Lead Manager: Sal Maughan

Summary of Corporate Risks as at 15th March 2012

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
1153	Privacy & Dignity issues for service users in the CDU/Pit Stop within the ED department	MED	6	TREAT	17-Aug-2011	18-Apr-2012	Executive lead: Suzanne Rankin Lead Manager: Steve Crouch
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	MED	6	TREAT	12-Mar-2008	18-Apr-2012	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	16-May-2012	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Sal Maughan
Tolerate: Accept the risk at its current level of risk							
1110	Loss of NHS income arising from damage to property.	HIGH	8	TOL	20-Jan-2011	28-Mar-2012	Executive Director: John Headley Lead Manager: Miriam Moore
1113	Fraud and Corruption	MED	6	TOL	2-Feb-2011	18-Apr-2012	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 15th March 2012

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											
1150	Underperformance of CIP Programme in 2011/12	The financial strategy of the Trust requires overall savings of £12m in 2011/12. Underachievement of £12m would lead to the financial plan not being achieved, with a failure to obtain a Monitor financial risk rating of 3 at year end, and a further risk to the financial sustainability of the Trust.	12	HIGH	29-Jun-2011	15-Apr-2012	*All previous updates held on paper by the Quality department.* Nov 11: CIP plans continually monitored, performance issues addresses and substitute schemes identified where necessary including over-performance in some areas to compensate. **March 12: Positive focus continues to mitigate the shortfall against CIP plan; however, at this stage, the shortfall is inevitable. The goal is to mitigate the shortfall and focus on '12/13 activities to ease capacity and LOS challenges faced this year.**	*All previous updates held on paper by the Quality department.* Feb 12: Some success bringing future CIP plans on line early, focus on over-achievement areas whilst mitigating slipping schemes; continue with all other initiatives. **March 12: Overall the divisions have shown good progress to bridge any shortfall; however, capacity concerns within the Trust have had a significant and increasing detrimental effect on the overall CIPS value achieved. This is being addressed in a more realistic and thorough way to increase the surety of the '12/13 CIP plan, with decisions taken now that have sacrificed some CIP achievements in the current year for the longer term benefit of the Trust and its patients.**	8	HIGH	Executive Director: John Headley Key Personnel: Valerie Bartlett; Paul Gilmore and Mark Hinchcliffe

Corporate Risk Register as at 15th March 2012

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 accommodation. March 2011 - negotiate terms of new 2011/12 contract. Fast Steady Stop task group set up. Action plan monitored.	8	HIGH	26-Mar-2009	14-Apr-2012	*Previous Action Plan/s held on paper in the Quality department.* June 11: Brief DGMs and seek views on impact of new contract penalties and CQUIN for 11/12. Brief TEC and Board in June 2011 - contract terms, risks and penalties. Repeat briefing for DGMs to cascade. Negotiate revisions to PCT Day case/OP procedure levy. Shadow-monitor bought-out challenges in year 11/12. Continue prior approvals process and C2C referral monitoring with Thames Medical. **August 11: Finalise the Trust's proposed business rules for OP Procedure vs Day case contract challenge and send to PCT, to apply to M4 data.** **Seek second review of prior approvals process with Thames Medical.**	*All previous updates held on paper by the Quality department.* Oct 11: - Review data challenge documentation to ensure process is followed - Work with PMO to ensure project plans in place for all CQUINS - Focus on ensuring Q1 closed and by end of month all previous months data challenges returned to PCT Nov 11: - Seek to refocus resource on data challenges in conjunction with Finance and Information departments - In half year reviews ensure that all department leads are achieving CQUIN outcomes - Initiate process of managing activity to contract levels with the Division Dec 11: No change Jan 12: The year is drawing to a close with only the 18 week penalty known to be applied. At this time the Readmissions penalty is tracking within budget. **March 12: Current action plan remains.**	6	MED	Executive Director: John Headley Lead Manager: Stephen Hepworth

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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	28-Mar-2012	*Previous Action Plan/s held on paper in the Quality department.* Oct 11: On-going discharge training for ward MDT teams to support improved understanding of roles & responsibilities relating to discharge. Daily 8am board rounds supports coordination of MDT discharge priority planning. Discharge competency now ratified and waiting for roll-out via discharge team & CPEs to all wards **Feb 12: Managed through the Project Management Office**	*All previous updates held on paper by the Quality department.* Oct 11: Discharge dash board monitoring medically fit patients with excess bed days, delays in HNA completion, EDD compliance. New Real time plan for improved understanding of where patients are in their discharge pathway including blocks to discharge . **Feb 12: Discharge dash board has not progressed - escalated by Suzanne Rankin but now likely to be linked to rollout of RealTime. RealTime now live on most medical wards - some further developments will come on stream in next month, and ongoing process of embedding. Further training for Matrons, Ward Managers and Band 6 nurses to embed good discharge practice planned for April 12. Short-term ward discharge coordinators being trained 22/2 to improve discharge and discharge coordination capacity.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Caroline Farrar

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ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1128	Capacity issues affecting quality of care for patients in AE	Due to lack of capacity and patient flow some patients are waiting for prolonged periods in the A&E department whilst the department continues to receive patients from the community. The department is unable to work efficiently to meet the many and varied needs of large numbers of patients. The quality of care and treatment provided at these times is therefore at risk of degradation.	12	HIGH	31-Mar-2011	27-Apr-2012	**March 2011 - Work with partners to reduce external demand on the A&E department (SECAMB and GPs).** **Internal Trust work to review and refine emergency and acute pathways to improve patient flow.** **Matron to review management of ambulance patients in the queue and consider co-horting to a safe ""surge"" area.** **ED Consultant to review medical team management and referral processes.** **Escalation policy to secure additional staff and resource to the department as required.** **Regular medical review of those patients with decision to admit.** **Prioritisation to move patients when beds become available on a clinical severity basis.** **Escalation of all patients requiring a specialist bed.**	Jan 12: A&E work streams for quality and safety in progress. New Clinical decision Unit opened for A&E which is effective. Pitstop functioning well with good communication with community partners SECAM. Escalation process agreed and launched. Standard criteria for patients referral to specialities launched. Two hourly board rounds introduced. A&E now being led by the Deputy Chief Nurse. Band 7 responsibilities have been identified and a senior nursing position being considered to include service management responsibilities, to be advertised in February. **March 12: The SECAMB surge management has greatly improved with ASPH becoming the most improved ED in relation to the Ambulance Handover target. This has been facilitated by the opening of the Pitstop area, a dedicated space for ambulances to handover and for the initial assessment and treatment to start prior to the patient being moved to elsewhere in the department. The hybrid senior nurse and management post is being advertised and in the process of being recruited to.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Steve Crouch

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1129	28 day readmission rate	High readmission rate indicative of poor quality. requirement to eliminate elective-emergency admissions and reduce emergency-emergency rate by 25% .	12	HIGH	31-Mar-2011	28-Mar-2012	March 11: Enhancing Quality pathways working to monitor and reduce readmissions for heart failure, pneumonia, Acute Myocardial Infarctions, Hips and Knees. North West Surrey working to reduce readmissions through enhanced joint working. Monitoring readmissions and examining themes by divisions at Clinical Governance Committee.	May 11: Introduction of virtual ward projects and Nursing home review project in process. Aug 11: No change Oct 11: No change Dec 11: No change **Feb 12: No change due to other priorities.**	3	LOW	Lead Manager: David Fluck

Corporate Risk Register as at 15th March 2012

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

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target.	12	HIGH	12-Mar-2008	18-Apr-2012	*All previous updates held on paper by the Quality department.* Aug 11: Key risk is performance against the Clinical Quality Indicators for A&E. The action plan to address this forms part of the unscheduled care project. Other actions to mitigate the risk include: - A daily breach review meeting with A&E - A formal, executive-led weekly review of the A&E action plan - A weekly operational performance meeting chaired by the Associate Director for Performance Improvement. **Jan 12: The key risk is delivery of a maximum waiting time of 4 hours in A&E as the Trust failed to meet this standard during Q3. As a result, the recovery plan has been reviewed and revised and the leadership team has been strengthened to support delivery. (A copy of the plan is held in the Quality Dept)**	*All previous updates held on paper by the Quality department.* July 11: Whilst the Trust delivered its Q1 performance, from Q2 the indicators change and there are risks over three of these indicators - failure to deliver more than two indicators will drop the Trust to amber green performance and ideally the Trust is seeking to deliver on all five. Three standards remain at risk during this quarter: (1) 95th percentile on total time (2) Unplanned reattendance rate and (3) 95th percentile for initial assessment *(more detailed information given on update form)* Further action will be developed on the back of the breach analysis which is due to complete by 18th July 2011. August 11: See Action Plan October 11: The Trust has achieved an overall performance rating of green for quarter 2. It is anticipated that this level of performance will continue in quarter 3, although ensuring that 95% of patients spend less than 4 hours in the A&E Department remains a risk. **Jan 12: See Action Plan**	4	MED	Executive Director: Valerie Bartlett Contact: Claire Braithwaite

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1130	Lack of assurance of robust adult safeguarding procedures	There is inadequate assurance that safeguarding concerns from external partners particularly around discharge of vulnerable patients, are being adequately addressed. Low numbers of staff have received adult safeguarding training. May 11: Heads of Nursing now taking the lead for delivery of operational safeguarding 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	9	HIGH	31-Mar-2011	2-May-2012	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. **Oct 11: Safe Guarding medical lead approached- to be confirmed.**	Oct 11: Training well underway. We now have 1800 staff trained. Further training sessions organised for the rest of the year. Two subgroups formed for training and policy development. Policy currently in review which will be more user friendly and support staff in escalating concerns. Jan 12: Risk reduced to 9. Safeguarding training progressing with 70% of staff trained. Deprivation of Liberty (DOLS) and Mental Capacity Act (MCA) training organised for February and March, communications sent out to all who need to attend. New database designed to capture data for safeguarding concerns to go live in February. Policy and process for escalation complete. **March 12: Nurse recruited into Safe Guarding role. Training continuing to progress. Until nurse starts, this is still an operational risk.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1147	The use of escalation beds Trust wide compromises patient safety and dignity	Significant capacity issues affecting both hospitals which has meant escalation beds are necessary and sometimes located in areas not routinely used for in-patient activity and therefore do not always provide the best quality experience. Some examples of impact upon elective surgery and procedures are noted. This represents poor patient experience -it also has an impact on the Trust finances and external targets.	9	HIGH	17-Jun-2011	2-May-2012	Immediate actions include: - Making sure patients are accommodated in the right place, and not in escalation areas. - Moving as much planned activity as possible to Ashford, with the right support, so St Peter's can concentrate on acute care. - Making sure we manage our beds in a better way so we don't have to keep moving patients around our wards. - That staff understand what the alternatives to acute admission are and that they know how to access these services. - Improving our multi-disciplinary ward rounds and discharge processes.	Jan 12: Risk has now been reduced although remains set at High. Permanent staff in place and ward manager position secure. Matron cover increased with sound focus on the escalation areas. Consultant and therapy cover being actioned to ensure robust continuity and stability to maintain the flow. Day Surgery increased at Ashford and Day Surgery unit at SPH now used for cardiology angios. **March 12: Swift ward plan in place to address nursing medical short fall inconsistency. Therapy and Phlebotomy support sought, and work underway to reconfigure bed base and substantiate swift with a nursing establishment.**	3	LOW	Executive Director: Suzanne Rankin Contact: Vanessa Avlonitis

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	NPSA safer practice notice to highlight issues related to early identification of failure to act on radiological imaging reports. The deadline for closure of this alert was February 2008. In summary patient safety incidents are being caused by a failure to acknowledge and act on radiological imaging reports. Radiology imaging tests are requested by a registered health professional that relies on a report and image usually generated by a radiologist or radiographer. The report and image are sent to the referring health professional, who then acts on the result. The system for requesting radiology imaging tests and sending reports to the referring health professional is unreliable and has been proven to fail. The Trust has had several cases of missed diagnosis related to this issue and most recently an SUI. Despite ongoing work to address this, the Trust has not been able to resolve the issues. Risk patients and Trust reputation.	6	MED	2-Feb-2011	18-Apr-2012	1. For inpatients, the printed Code 5 priority reports from x ray should be sent not only to the ward but also directly to the consultant identified as the requesting physician at the time of request. 2. Before junior Drs are allowed to order CT scans they must discuss and get approval from the on call consultant 3. The radiology department should not accept requests stating "consultant unknown" and it should be the responsibility of the requesting doctor to complete this field. If possible "consultant unknown" should be removed as an option 4. A pilot of CRIS software "Communicator" package is underway whereby the referring clinician may be notified either by text, e mail or bleep of an urgent result that they should review. If this is successful consideration should be given to extending the use of this process to inform consultant staff directly of any code 5 report issued on inpatients under their care. A process should be developed so that receipt is formally acknowledged. *(More on notification form)*	**Jan 12: The pilot for the Code 5 Tracker finished in December. Lessons learned to date have been incorporated into the functionality and deployment across the Trust will commence in Paediatrics. As deployment progresses, the functionality will be enhanced as feedback from clinicians is received. It is recommended that the status for this alert remain at amber until such time that the Code 5 Tracker is deployed across the Trust. It is estimated that deployment will be completed by end February 2012.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: David Fluck

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1083	Corporate lack of Trust Social Services worker post for Paediatric Services	Currently there is no designated social services worker to lead on safeguarding children by the local authority. The risk is that vulnerable children could be missed or become unsupported by the lack of continuity of a designated social worker identified for the Trust. This risk applies to wherever children are cared for within the Trust, specifically Paediatric A&E, Paediatric wards and Paediatric Outpatients. Risk to patients, service, reputation and failure of statutory duty. **July 11: The wording of above has been looked at by Paul Crankshaw, who has decided that the risk description does not need to be re-written.**	6	MED	21-Sep-2010	11-Apr-2012	The risk has been on the Children's Services Risk Register since December 2009. Since which time steps have been taken, including the naming of a link social worker and updating of processes in A&E, however the risk still persists. Following escalation, our Chief Executive wrote to the Chief Executive of Surrey County Council to arrange a meeting. Since which time our Chief Executive has spoken on the telephone with Andy Roberts, Strategic Director for Children, Schools and Families who has agreed to do a fast review of the situation.	*All previous updates held on paper by the Quality department* Mar 11: Continue ongoing monitoring of the situation i.e. low threshold for reporting of adverse incident which occur as a result of the lack of SW. Paediatric Consultants asked to complete incident form when they feel that the absence of a hospital paediatric social worker or the lack of results filing in the notes has caused any sort of problem. July 11: Exploring development of a further safeguarding post to support Named Nurse. Nicky Love & JA Dowie to compile job description for this post. Sept 11: Risk closed (Helen Sibley) Oct 11: Risk reopened (Suzanne Rankin) until post filled. **Jan 12: An alternative approach has been agreed with the Safeguarding team. A nurse is to be employed to assist the Lead Child Protection nurse. Interviews taking place this month. Risk will be removed when post is filled.**	3	LOW	Executive Director: Suzanne Rankin Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1057	Possible loss of patient confidence in the Complaints service.	The Trust is working to devolve responsibility for the drafting of complaint responses to Divisions. Complaints management is governed by Legislation, CQC and NHSLA standards. Also monitored by PHSO. There is a need to adhere to governance standards and continue to maintain high standards in complaints management while ensuring a high quality response. Risk to Trust reputation and failure of statutory duty	6	MED	12-Aug-2010	8-May-2012	1. Resource library on T drive including guidance notes and 'top tips'. 2. Clarity of expectation and performance standards with associated monitoring (via Customer Affairs and Performance meetings). 3. Training with Directorates as required. 4. Continued process of qualitative assurance. (Complaints Manger, Head of Customer Affairs, Chief Nurse). 5. Complaints Office support within Divisions. 6. Ongoing discussion with General Managers re implementation. Nov 10: Review at the next CMG meeting in February 2010. Nov 11: In addition to the action plan in place, there is a more recently developed 4 week improvement plan in place to treat this risk and clear the current backlog of complaints by mid December. The plan ha **Feb 12: Improvement plan implemented**	*All previous updates held on paper by the Quality department.* Nov 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 4 November 2011 where a report was presented and it was agreed that the devolved process was not fully embedded. As such the risk remains unchanged. The action plan will continue to be monitored and will be reviewed at the next Complaints Monitoring Group meeting in Feb 2012. **Feb 12: Risk and action plan to treat were discussed at the Complaints Monitoring Group on 10 February. It was agreed that whilst improvements in the complaints handling process were evident, a sustained improvement could not be guaranteed. The group agreed the risk should remain as it is and be reviewed at the next Complaints Monitoring Group meeting on 4 May 2012.**	2	LOW	Executive Director: Suzanne Rankin Lead Manager: Sal Maughan

Corporate Risk Register as at 15th March 2012

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

Corporate Risk Register as at 15th March 2012

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions. Risk to patients and Trust reputation	6	MED	12-Mar-2008	18-Apr-2012	*All previous action plans can be accessed from paperwork held in the Quality department.* Aug 10: Trust wide MRSA action plan updated 9th August and local blood culture action plan formulated following the five MRSA bacteraemia Root Cause Analysis. Details held with paper copy update. Jan 11: Action Plan updated December 2010. to reflect that all the actions remain ongoing **March 11: Action Plans have been updated to reflect the current status**	*All previous updates held on paper by the Quality department.* Jan 11: No MRSA bacteraemia since 29th July 2010 The instigation of the dedicated blood culture taking service has been very successful. Aseptic technique competencies continues to be rolled out trustwide for healthcare staff. April 11: Since July 2010 the Trust has had no MRSA Bacteraemia and therefore have not breached trajectory for 2010/11. Also Clostridium difficile rates are significantly below trajectory for 2010/11 Action Plans updated and clinical interventions remain ongoing . Sept 11: Risk level reduced from medium to low. Oct 11: The Trust has now had 2 MRSA bacteraemia (April- September 2011/12) of a trajectory of 4. Vigilance in practice is paramount not to exceed our trajectory. Risk level reverted to medium. **Jan 12: No MRSA bacteraemia since September 11, therefore well under target to date.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Linda Fairhead

Corporate Risk Register as at 15th March 2012

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	16-May-2012	*All previous updates held on paper by the Quality department.* Dec 10: 1. Patient information subgroup formed 2. Patient Access subgroup formed 3. Identify top three trends from 'your' feedback 4. Triangulating data from 'Your' Feedback 5. Discharge planning group with matrix. 6. Focus on End of Life Care. 7. Incentivisation of staff. 8. Relaunch the Patient Experience indicators. **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.**	*All previous updates held on paper by the Quality department.* August 11: 10 point plan drafted and implementation ongoing. Increased focus during July - month of patient sampling for inpatient survey. Ongoing surveys: AE (spotlight) and OPD (National). Oct 11: The Trust has recently received its ['raw' results following the 2011 outpatient survey. These results will be weighted by the CQC to enable benchmarking across all acute Trust. The CQC results are anticipated in January 2012. In the meantime, action planning will commence. In addition, the Living our Values Programme continues. **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.**	6	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Sal Maughan

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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	28-Mar-2012	The risk could be reduced by purchasing insurance cover but this is costly and the Board has decided not to purchase cover for loss of NHS income at this stage. In reaching this decision the Board noted one mitigation against the risk was that the Trust operated from two discrete sites. The Trust has Business Continuity Plans (including Disaster Plans) in place that should help mitigate the amount of down time that would lead to such a loss of NHS income.	July 11: The risk score has been reviewed and is unchanged. When the renewal process is started for the Trust's existing top-up insurance for property damage/loss of non-NHS income the cost of cover for loss of NHS income will ascertained and the treatment of this risk reviewed. The renewal date for the existing insurance is 30/11/11 so the renewal process is expected to commence towards the end of Quarter 2. Aug 11: No change Oct 11: No change, apart from a delay in commencing the insurance renewal process. This is now expected to commence before the end of October 2011. **Dec 11: The Trust's existing top-up insurance for loss of non-NHS income was renewed with effect from 01/12/11 but a review of the nee d for cover for loss of NHS income has been delayed and will now take place in Q4 of 2011/12.**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

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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	2-Feb-2011	18-Apr-2012	*Previous Action Plan/s held on paper in the Quality department.* **Jan 12: In view of the level of proactive work (designed to develop an anti-fraud culture) 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.**	*Historical progress reports held on paper in the Quality department.*	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore