Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
29th April 2010

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 15th April 2010, and highlights: ▪ 2 New Risk added since 25th February 2010 ▪ 5 Existing Risks where the risk level has changed since 25th February 2010 ▪ 1 Risk with changed treatment objectives since 25th February 2010 ▪ 0 Risk closed since 25th February 2010 This report now includes a Target Risk Score should all the mitigating actions be successfully achieved.
ASSURANCE (Risk) / IMPLICATIONS	The Corporate Risk Register report provides assurance that relevant risks have been identified as corporate risks and by doing so there are action plans in place to mitigate the risk. The report contains summary information, the full Corporate Risk Register, as well as details of those risks closed in the period.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	The Corporate Risk Register is required by the Department of Health and is a particular requirement of the NHS Litigation Authority, as well as ALE. It is a fundamental requirement of Monitor when the Trust becomes a Foundation Trust.
The Trust Board is asked to:	The Trust Board is asked to note the contents of the Corporate Risk Register.
Submitted by:	Marty Williams, Clinical Risk Manager On behalf of, Caroline Becher, Chief Nurse
Date:	29th April 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
29th April 2010

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 February 2010

New Risks added since 25th February 2010

ID	Title	Description	Present Objective	Risk level	Responsibility Owners
988	VTE phrophylaxsis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	TREAT	HIGH	Executive Director: Mike Baxter Lead Manager: Clinical Directors Contact: Mike Baxter (Sarah White PA 2839)
1006	Failure to comply with CQC registration	The new regulatory process (Care Quality Commission) is in place from April 2010. There is a change of approach with a focus on standards and with more complex processes required to assure that all regulated activities at both hospital locations meet all required standards. Risk to patients and staff, Trust reputation and failure of statutory duty.	TREAT	HIGH	Lead: Sarah Johnston Key Personnel: Essential standards owners, directorate CDs, GMs Matrons and CG managers. Contact: Sarah Johnston

Existing Risks where the risk level has changed since 25th February 2010

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1B)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions	Mar 10: MRSA and C diff figures remain on trajectory. All areas now have isolation facilities. Assimilated CQC ward visits continue by the Chief Nurse and Consultant Nurse Infection Control. Risk reduced to medium	HIGH	MED	Executive Director: Caroline Becher Contact: Linda Fairhead
907	Service failure- Swine Flu Pandemic	The Swine Flu Pandemic may cause a high number of staff sickness and absence and a high number of patients (adult and paediatric) requiring hospital admission and intensive care consequently there is a risk of service failure. The key issues will be: (a) Service provision and performance targets (Business continuity) (b) Suboptimal patient care (c) Staff fatigue (d) Demand and capacity (e) Ethical considerations (f) Supply chain failure At risk: Service failure; Reputation; National targets; Statutory duty	Mar 10: Experience throughout the Winter months both locally and across the UK has shown significantly lower than expected levels of infection from the Swine Flu virus. The Swine Flu Hotline is now closed and D of H statistics indicate low levels of infection and ,since Christmas, high vaccination figures for designated risk groups. The risk is at present low.	HIGH	LOW	Executive Director: Valerie Howell Lead Manager: Valerie Howell Key Personnel: Valerie Howell Contact: Valerie Howell from Jan 10
890	Failure to implement internal auditor recommendations	At present the Trust has failed to implement the recommendations of the internal auditor concerning the risk of (a) theft or loss of patient's property (b) identity theft and legal action against the Trust (c) negative publicity in the local press.	March 10: Auditors recommendations have been incorporated into policy. This has now ben ratified and forwarded to auditors for comment. Once returned will be placed on Trustnet. Risk reduced to medium by Sue Brown.	HIGH	MED	Executive Director: Caroline Becher Key Personnel: Sue Brown, Debbie Palmer, Colin Matthew Lead and contact: Sue Brown
816	Failure to develop IT infrastructure appropriately. (BAF 4a)	The IT Asset Inventory is not accurate and identified owners are not routinely recorded. There is an absence of a detailed software / systems register. There are insufficient resources to develop new technologies to maximise return on investment. Competing projects demanding resources impedes progress and development of new technologies in a controlled and logical manner.	ntation. 4. IT Roadmap developed. 5. Review completed (risk 745) changed to tolerate. 6. Completed 7. Due to take place Q1 2010. Risk reduced to Medium.	HIGH	MED	Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
887	Loss of Person Identifiable Data	There exists the possibility of the loss of PID as a result of a lack of understanding from staff regarding personal responsibility for data and information governance (IG). At risk: Patient safety, Financial Loss, Reputation, Failure of Statutory duty.	Mar 10: Port control implemented, Information Governance training nearly completed for all staff, encrypted memory sticks available and all laptops encrypted. Risk now low.	MED	LOW	Executive Director: Mike Baxter Key personnel: Robin Gammon, Alex Williams Lead: Robin Gammon Contact: Alex Williams, Tracy Street

Risks with changed treatment objectives since 25th February 2010

ID	Title	Description	Risk level	Previous Treatment	Present Treatment	Reason	Responsibility Owners
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers namely Lodestone and Inhealth.	MED	Tolerate	Treat	Mar 09: Contracts have been reviewed by the Trust's legal team to ensure minimal risk financially and to limit other risks. Due diligence has been completed. July 09: 'In Health' have renewed the contract for 18 months, however there is still a chance of other factors leading to a break in the service. Risk Tolerated **Mar 10: The Trust will retender for the above contract in 2010. Risk returned to Treat**	Executive Director: Valerie Howell Contacts: Catherine Townsend

Risks closed since 25th February 2010

None

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Date Requested	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk								
806	Out of date Trust policies.	HIGH	12	TREAT	27-Oct-2008	24-May-2010		Executive Director: Caroline Becher Lead Manager: Sarah Johnston Contact: Tina Hopkins
837	Delay in Psychiatric assessment - A & E and MAU	HIGH	12	TREAT	9-Apr-2009	24-Jun-2010		Executive Director: Valerie Howell Key Personnel: Robert Jeffries, , Heather Clark, Claire O'Brien, Contact: Robert Jeffries cc Philippa May
988	VTE phrophylaxsis assessment shortfall	HIGH	12	TREAT	25-Feb-2010	10-Apr-2010	7-Apr-2010	Executive Director: Mike Baxter Lead Manager: Clinical Directors Contact: Mike Baxter (Sarah White PA 2839)
768	Staff recruitment and retention. (BAF 2b)	HIGH	12	TREAT	12-Mar-2008	15-May-2010		Executive Director: Raj Bhamber Key Personnel: Kate Clarke, Cathy Dennis, Elaine Beaumont, Judy Henville, Harriet Stephens Contact: Raj Bhamber, Kate Clarke
832	Loss of income-Contracts. (BAF 3a)	HIGH	12	TREAT	26-Mar-2009	25-Mar-2010	16-Mar-2010	Executive Director: Paul Bentley Lead: Sue Robertson Contact: Sue Robertson (Head of Planning and Performance)
1006	Failure to comply with CQC registration	HIGH	12	TREAT	14-Apr-2010	12-May-2010		Lead: Sarah Johnston Key Personnel: Essential standards owners, directorate CDs, GMs Matrons and CG managers. Contact: Sarah Johnston
769	Foundation Trust work plan	HIGH	10	TREAT	12-Mar-2008	10-May-2010		Executive Directors: Paul Bentley Contact: Paul Bentley
767	Privacy and Dignity issues for service users. (BAF 1e)	HIGH	9	TREAT	12-Mar-2008	20-May-2010		Executive Directors: Caroline Becher Contact: Sue Brown
815	Potentially vulnerable network resilience and/or disaster recovery for IT programmes. (BAF 4a)	HIGH	8	TREAT	6-Feb-2009	5-Jul-2010		Executive Director: John Headley Manager: Robin Gammon Contact: Margaret Broomfield, Laura Ellis-Philip
764	Delivery on all Performance Targets. (BAF 1a, 1b)	HIGH	8	TREAT	12-Mar-2008	25-May-2010		Executive Director: Valerie Howell Contact: Valerie Howell

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Date Requested	Responsibility Owners
766	Patient satisfaction scores. (BAF 1d)	HIGH	8	TREAT	12-Mar-2008	14-May-2010		Executive Director: Valerie Howell, Caroline Becher Contact: Caroline Becher, Valerie Howell
894	Not being licensed for FT status (BAF 3b)	HIGH	8	TREAT	2-Sep-2009	11-Jun-2010		Executive Director: Paul Bentley Lead: Paul Bentley Contact: Paul Bentley
890	Failure to implement internal auditor recommendations	MED	6	TREAT	6-Aug-2009	20-May-2010		Executive Director: Caroline Becher Key Personnel: Sue Brown, Debbie Palmer, Colin Matthew Lead and contact: Sue Brown
847	Under delivery of CIP programme. (BAF 4b)	MED	6	TREAT	20-May-2009	25-May-2010		Executive Director: Valerie Howell Key personnel: Valerie Howell, Barrie Jones, Jenny Johnson, Charlotte Freeman. Contact: Barrie Jones
816	Failure to develop IT infrastructure appropriately. (BAF 4a)	MED	6	TREAT	6-Feb-2009	2-Jul-2010		Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	15-Jun-2010		Executive Director: Valerie Howell Contacts: Catherine Townsend
763	Health Care Acquired Infection & National Targets. (BAF 1B)	MED	6	TREAT	12-Mar-2008	17-May-2010		Executive Director: Caroline Becher Contact: Linda Fairhead
907	Service failure- Swine Flu Pandemic	LOW	3	TREAT	16-Sep-2009	4-Jul-2010		Executive Director: Valerie Howell Lead Manager: Valerie Howell Key Personnel: Valerie Howell Contact: Valerie Howell from Jan 10
887	Loss of Person Identifiable Data	LOW	3	TREAT	17-Jul-2009	7-Jul-2010		Executive Director: Mike Baxter Key personnel: Robin Gammon, Alex Williams Lead: Robin Gammon Contact: Alex Williams, Tracy Street
Tolerate: Accept the risk at its current level of risk								
848	Financial loss due to uninsured claims	HIGH	12	TOL	20-May-2009	11-Jun-2010		Executive Director: John Headley Lead: Colin Matthew, John Headley Contact: Colin Matthew
745	IT: Over reliance on key individuals with specialist knowledge.	MED	6	TOL	10-Jan-2008	24-Aug-2010		Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk											
806	Out of date Trust policies.	The Trust policy database has only 13% of its policies in date. (October 08) Risk to patients, staff and service. Non compliance and risk to obtaining Foundation status	12	HIGH	27-Oct-2008	24-May-2010	Update the database. Clarify processes and communicate requirements to relevant departments. Aim to complete the work by mid 2009. June 09: Updating policies to be prioritised with a new action plan to be agreed by IGAC. Apr 09: Continue to remind staff of out of date policies. Review of whole process is planned for May. Sept 09: Now to concentrate on organisational/financial risk policies. HR policies are being addressed externally. Process under review. Dec 09: 1. To review progress and plans with the Executive early in 2010. 2. 29% of all policies are for nursing so identify those out of date and investigate the use of the Royal Marsden manual to replace some nursing policies. Mar 10: To monitor HR policies more closely. TH to support Jeremy Overs to clean up current policies and replace. Now establishing owners for out of date nursing policies.	Dec 08: Now 18% of policies in date. Database now up to date. Flow chart to show the process of policy ratification published on Aspire. Importance of in date policies communicated via Aspire. Now classified as a Corporate risk. Apr 09: Policies apparently being reviewed but finalised policy not reaching the Quality department. Processes not working for maintaining good control of policies. Refer to Action Plan. June 09: Discussed at IGAC due to lack of progress. Refer to action Plan. Sept 09: 24% of policies now in date. Dec 09: Now 28% in date. Flow of updated policies has slowed, other policies are now out of date, reminders sent. Finance, H&S, risk almost complete. HR still have 78 policies to update out of a total of 119. Mar 10: Continued progress with HR Policies. Finance, organisational, employment and risk management still have 73 out of 116 policies out of date. Currently 33% of policies are now in date. A new intranet page developed providing clear indication to owners of their policy 'in date' status to drive a more proactive approach by the owners.	4	MED	Executive Director: Caroline Becher Lead Manager: Sarah Johnston Contact: Tina Hopkins

ID	Title	Description	Rating (current)	Risk level (current)	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)	12	HIGH	9-Apr-2009	24-Jun-2010	1. Escalation of concerns/ risk 2. Develop a risk assessment form which would be completed in A & E / MAU prior to referral to psychiatric services. 3. Urgent review of psychiatric services now in progress. Mar 10: No change. A meeting is to be arranged with the Psychiatric team to discuss the issues.	Sept 09: Escalated to the Chief Executive. No progress otherwise Dec 09: No developments or progress Mar 10: No progress due to at present not having the support to offset the potential cost incurred when this happens.	2	LOW	Executive Director: Valerie Howell Key Personnel: Robert Jeffries, , Heather Clark, Claire O'Brien, Contact: Robert Jeffries cc Philippa May

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
988	VTE phrophylaxsis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	12	HIGH	25-Feb-2010	10-Apr-2010	1. Establish VTE implementation group. 2. Change in prescription charts. 3. Increased policing by matrons and senior doctors. 4. On-going audit and review. 5. Direct addressing of under performance.	Promotional e-mail concerning VTE sent to all senior nurses on 31st March 10		LOW	Executive Director: Mike Baxter Lead Manager: Clinical Directors Contact: Mike Baxter (Sarah White PA 2839)

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
768	Staff recruitment and retention. (BAF 2b)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff.	12	HIGH	12-Mar-2008	15-May-2010	Sept 09: New action plan: 1. Targeted recruitment to match national and international sources of supply 2. Promote key services and leadership through media campaign e.g. 'Join the Team', Make a Difference' 3. Provide high quality temporary staff to fill recruitment and retention gaps. 4. Targeted recruitment and retention plans (including new roles and ways of working) 5. Improve staff satisfaction (as a retention tool) 6. Increase appraisal coverage 7. Targeted clinical development and training programmes to address hot spots Dec 09: 1. Develop a Trust- wide Recruitment & Retention Strategy to include R & R steering group. 2. Develop an in-house overseas nursing programme (adaptation) 3. Weekly Nursing recruitment planning/monitoring meetings with Medicine, Theatres, Emergency Services and Maternity. 4. Weekly Staffing recruitment planning/monitoring meetings with Emergency Services, Anaesthetics and Paediatrics. 5. Participation with Medical Training Initiative.	May 09: Action Plan updated and risk 838 (work permits) incorporated within this risk. Sept 09: 1. New action plan 2. Successful recruitment programmes in Dubai and Ireland. Local media spotlight on Midwifery. 3. Temporary staff 'fill rates' adequate 4. Meetings held in each BC - R and R plans reviewed at PRMs. Positive local staff survey results and corporate action plan being implemented. Positive progress against trajectory. Dec 09: Recruitment: Vacancy rate at Nov. end 8%, 12% for nursing down from 15% at October end. Clinical measurements and Nuclear medicine successful with staff starting first qu. of 2010. Some reduction in ODP vacancy rate with development of Anaesthetics nurse module for Theatre nurses. Retention: Turnover is 12%,stability 90% at Nov. end. Appraisal coverage now 58%. Staff Survey completed by 63% of staff. Areas of vacancy and high turnover are known. Some international recruitment successful for nurses and doctors. Mar 10: Recruitment: Vacancy rate is 9.08%, 14.36% for nursing, up from 12.93% (Jan). Vacancy in SAU, Medical and Surgical wards, Maternity. ODPs / Anaesthetic nurse vacancy higher than average. Medical staffing in Paediatrics, Anaesthetics and Emergency. Retention: Turnover rate is 13% and stability 89%. Appraisal coverage now at 68% for previous 12 months. Nursing: Details given on paper update as	8	HIGH	Executive Director: Raj Bhamber Key Personnel: Kate Clarke, Elaine Beaumont, Judy Henville, Harriet Stephens Contact: Raj Bhamber, Kate Clarke

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
832	Loss of income-Contracts. (BAF 3a)	There is a loss of income due to contracts based on new tariffs and HRG and PCT data challenge processes. CBSA clearing system.	12	HIGH	26-Mar-2009	25-Mar-2010	1. Robust review of monthly activity and income against plan. 2. Performance reports set up for BCMs. 3. Contract data challenge process largely automated now, allowing more robust counter-challenge. 4. Executive team and BCMs to be briefed on changes to the contract and actions required. Nov 09: 1. Agree full year value contract challenges (including TNRF) to give financial certainty. 2. Conduct full reconciliation of SUS and SLAM against CBSA reconciliation statement - or pursue formal mediation / reconciliation with SHA if not resolved satisfactorily.	May 09: Briefing sessions run for BCMs on 6th May 09. Presentation about PCT contract and financial implications to TEC on 5th May 09. Detailed review of data shared with CDs and BCMs. Jul 09: Actions taken in several specialties particularly to reduce non-GP referral and mitigate against contract challenge loss of income. Challenge for Q1 currently being validated. Position on new: follow-up challenge looks improved. Sept 09: Contract challenges not formally signed off yet for Q1. Main issue is resolving the baseline, rather than the challenge values. Risk increased from H to E Nov 09: Full year value for contract challenges of £1.625m agreed verbally with PCT by Paul Bentley. This will resolve the risk on contract challenges for the rest of 09/10. Further details in hard update copy. Risk reduced. Dec 09: Details for Nov now signed off. Q1 reconciliation value settled. Similar process to be followed for Q2 and month 7 reconciliation.	12	HIGH	Executive Director: Paul Bentley Lead: Sue Robertson Contact: Sue Robertson (Head of Planning and Performance)

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1006	Failure to comply with CQC registration	The new regulatory process (Quality Control Commission) is in place from April 2010. There is a change of approach with a focus on standards and with more complex processes required to assure that all regulated activities at both hospital locations meet all required standards. Risk to patients and staff, Trust reputation and failure of statutory duty.	12	HIGH	14-Apr-2010	12-May-2010	1. Process created to enable assurance to be provided which includes corporate and directorate responsibilities. 2. Evidence being loaded onto Performance Accelerator for a full review in June with progress reports to IGAC. 3. Training provided for corporate owners and support provided to directorates for report writing. 4. Work with Jane Gear (Head of Corporate Affairs) to consider how best to triangulate information to assure the Trust Board that regulated activities are adequately met.			LOW	Lead: Sarah Johnston Key Personnel: Essential standards owners, directorate CDs, GMs Matrons and CG managers. Contact: Sarah Johnston
769	Foundation Trust work plan	The Foundation Trust application has significant potential to divert Executive and Clinical Directors from achieving our ASPH organisational objectives.	10	HIGH	12-Mar-2008	10-May-2010	Provide clarity as to the process, timetable and the need for resources. Feb 10: Revised action plan to reflect the view of the PWC and SHA. Action plan details in file. (Refer to risk 894)	Sep 09: Since identifying the original risk, the Trust has submitted 4 reviews of the business plan, and the performance of the Trust has improved. PB has lead responsibility for delivery of the FT workplan. TEC and Trust Board agendas ensure achievement of organisational objectives ie monitored and maintained. Feb 10: Final draft of the IBP approved by the Board in Jan 10 and submitted to the SHA.	3	LOW	Executive Directors: Paul Bentley Contact: Paul Bentley

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
767	Privacy and Dignity issues for service users. (BAF 1e)	Potential failure to improve upon Privacy and Dignity issues for service users.	9	HIGH	12-Mar-2008	20-May-2010	Require strict adherence to the reduction and ultimate elimination of the acceptance of mixed sex gender accommodation for patients in all general areas and improved awareness and action to minimise the impact on patients in assessment and high intensity care arenas. Sept 09: Act to eliminate patient exposure to mixed sex accomodation	May 09: Ongoing Sept 09: The remodelling programme is on track. Mar 10: All required areas should be single sex compliant by the end of March 2010.	4	MED	Executive Directors: Caroline Becher Contact: Sue Brown

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
815	Potentially vulnerable network resilience and/or disaster recovery for IT programmes. (BAF 4a)	The risk results from an ABSENCE in (a) Fire suppression in AH computer room (b) written Disaster Recovery and Backup procedures (c) agreed business critical systems and order of priority (d) full use of the two computer rooms (e) sufficient redundant network links between core and edge.	8	HIGH	6-Feb-2009	25-Apr-2010	1. Increase network resilience to include server virtualisation and shadowing/mirroring systems between sites (see risk 727) 2. Implement disaster recovery plan for IT-external audit review underway which will be cross referenced with Business Continuity Plans and the IT Portfolio (see risk 751) 3. Install fire suppression controls in the AH computer. room. (see risk 752) 4. Develop a robust backup strategy which will support the growth of the future development of the IT Infrastructure. 5. Document backup procedures and review on a regular basis. 6. Obtain Trust agreement on business critical systems and orders of priority. 7. Implement additional redundant network links between core and edge.(see risk 754) 8. Establish regular External/Internal Audit reviews.	May 09: New equipment has been purchased (blades, chassis, servers). Server virtualisation has begun. Disaster Recovery Plan action plan in place. Fire suppression contract to go out to tender. Business Impact Analysis Continuity Plan now in place and under revision to further improve. Plan to upgrade Core Switches in 2010/11. Audit reviews with Chantry Vellacot now regular. Nov 09: A capital bid will be submitted for a fire suppression system to be installed in the Ashford computer room, led by Harold Teague (Fire Advisor). Disaster Recovery project in progress and on target to have robust and tested DR strategy in place by March 2010. Feb 10: Capital bid for fire suppression to be moved forward by Dave Axton. Disaster recovery plan nearing completion. Virtualisation project underway in March 2010. IT systems portfolio now web based and Responsibilities of System Owners and Administrators are detailed in the Information Security Policy due to be ratified by the IG Steering Group. Written DR procedures for Priority One systems underway, with several completed. Redundant network links now in place. April 2010: 1. Plans are in place for server virtualisation. More network resilience plans to follow. 2. DR Plan now developed, as is IT Systems Portfolio. Next steps in April 2010: DR Group workshop, take forward the Systems Portfolio via 1-1 meetings with system owners and administrators. 3. Harold Teague now ready to order. LEP has approved expenditure. 4. Backup strategy will be developed as part of the Server Virtualisation project.		LOW+K12	Executive Director: John Headley Manager: Robin Gammon Contact: Margaret Broomfield

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
764	Delivery on all Performance Targets. (BAF 1a, 1b)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target throughout 2009.	8	HIGH	12-Mar-2008	25-May-2010	May 2009 1. Detailed action plan in place to improve A and E performance. Weekly improvement meetings in place chaired by the ED. Key actions include workforce development; primary care at the 'front door' 2. In terms of 18 weeks, key actions are to provide outpatient clinic, theatre and ward activity to sustain patient's pathways of access in less than 18 weeks. 3. Full review of demand and capacity for all elective specialties. Feb 10: Closer working between patient pathway team and directorate to improve performance in orthopaedics and improve booking practice. Some outsourcing of work. Recovery plan in terms of four hour target focused on medical staffing at peak times and improved management capacity.	May 2009: Updated action plan July 09: Significant improvement in four hour performance delivered. Additional management support now in place in orthopaedics. Action point 3 now under way in orthopaedics. Feb 10: Orthopaedics expected to deliver Q4 on admitted and non admitted pathway. Significant in year improvement in A&E performance is being maintained. Apr 10: Progress against all key performance targets is strong and on track for the remainder of the financial year. Performance in Feb. and Mar. has been at the required level.	4	MED	Executive Director: Valerie Howell Contact: Valerie Howell

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
766	Patient satisfaction scores. (BAF 1d)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	8	HIGH	12-Mar-2008	14-May-2010	1. Require patient feedback to be fully utilised throughout the hospital sites to ensure that departments are receiving timely and relevant feedback on services from users and their carers. 2. Full implementation of the recommendations identified in a resulting action plan arising from the 2007 IP survey results and the 2008 A & E survey when received later in the year. 3. Ownership and leadership required from Executive leads to be identified on the 28th March 2008. Aug 09 the above and 4. Chief Nurse to meet with Matrons to discuss a development plan. This to take place during three days away from the hospital at low cost. Assistance provided by the SHA. Nov 09: The Medical Director & Chief Nurse will be introducing on Nov 5th a hand held audit toll to track progress & matron influence on standards.	Aug 09: 1. Comment cards introduced 2. Patients surveyed who were being treated during July 09 and May 09 outpatients. (outpatients received and not very positive) CQUIN Survey also conducted. Awaiting results of the National Adult in patient Survey. CQUIN showed some improvements. Sept 09: Two away days have been facilitated. Matrons re-launch undertaken during this month. Nov 09: Chief Nurse has now completed the matron development plan and clinical Fridays were launched in October. March 10: Remains a high priority. Matrons now high profile with new uniforms and expected to be actively available to patients. Latest data being processed.	6	MED	Executive Director: Valerie Howell, Caroline Becher Contact: Caroline Becher, Valerie Howell

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
894	Not being licensed for FT status (BAF 3b)	Not being licensed would be due to: 1. Organisational transformation 2. Lack of support from the Local Community, PCT/SHA, DH/Monitor 3. Lack of approval to proceed There is a risk of financial loss and loss of reputation.	8	HIGH	2-Sep-2009	11-Jun-2010	1. Rigorously managed project to deliver F.T 2. Robust project Plan and project management. 3. Approval of IBP final. 4. Organisational transformation program 5. Dummy FRP by EY 6. Board to Board with SHA 7. Complete action plan from PWC review Feb 10: Action Plan update provided and headed 'Report to Foundation Trust Project Board - Paper 3.0'	Feb 10: Further iteration of the IBP approved by the Board in January 2010. Action plan to deliver the work programme is maintained monthly by the FT Project Board. (Full paper copy details provided and headed 'FT Application - PWC / SHA actions Finance only') April 10: FT application now supported by the SHA and with D of H, however still await outcome. Challenge to be authorized as a FT is now more demanding. All controls in place to ensure progress.	3	LOW	Executive Director: Paul Bentley Lead: Paul Bentley Contact: Paul Bentley
890	Failure to implement internal auditor recommendations	At present the Trust has failed to implement the recommendations of the internal auditor concerning the risk of (a) theft or loss of patient's property (b) identity theft and legal action against the Trust (c) negative publicity in the local press.	6	MED	6-Aug-2009	20-May-2010	Review patient property policy and all procedures relating to the management of patients' property in accordance with the recommendations of the internal auditors report dated July 2009.	Sept 09: Auditor recommendations have been reassigned to new owners with a target date of the end of September 09. Nov 09: Action plan ongoing and proposed to be completed by Feb 10 March 10: Auditors recommendations have been incorporated into policy. This has now ben ratified and forwarded to auditors for comment. Once returned will be placed on Trustnet. Risk reduced to medium by Sue Brown.	1	LOW	Executive Director: Caroline Becher Key Personnel: Sue Brown, Debbie Palmer, Colin Matthew Lead and contact: Sue Brown

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
847	Under delivery of CIP programme. (BAF 4b)	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	6	MED	20-May-2009	25-May-2010	1. Create a demand and capacity plan for each Surgical specialty. 2. Theatre user group to be established to oversee the operational efficiency of theatres.	Sept 09: Local plans are underway to minimise the use of additional list, whilst balancing the need to reduce outsourced work. Surgical Capacity Planning Project has been initiated. Nov 09: Further Theatres CIPs generated. Capacity Planning Project underway. Lean project underway. Feb 10: A number of new CIPs identified for 2009/2010 to ensure the CIP is on course to achieve its target for the year end.	2	LOW	Executive Director: Valerie Howell Key personnel: Valerie Howell, Barrie Jones, Jenny Johnson, Charlotte Freeman. Contact: Barrie Jones

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
816	Failure to develop IT infrastructure appropriately. (BAF 4a)	The IT Asset Inventory is not accurate and identified owners are not routinely recorded. There is an absence of a detailed software / systems register. There are insufficient resources to develop new technologies to maximise return on investment. Competing projects demanding resources impedes progress and development of new technologies in a controlled and logical manner.	6	MED	6-Feb-2009	2-Jul-2010	1. Develop a systems register (from IT Systems Portfolio) and maintain an accurate IT Asset Inventory. 2. Upgrade/replace end of life/out of date hardware and software (partly risks 748 and 749) 3. Maximise return on investment by utilising infrastructure to full potential e.g Server Virtualisation (partly risk 727) 4. Develop Infrastructure/systems roadmap. 5. Review IT department organisation to facilitate staff resource to implement new technologies. 6. Establish regular External/Internal Audit reviews. 7. Conduct NIMM assessment and review. Nov 09: 1. PAS printer replacement project established. 2. Review of IT department organisation.	May 2009: IT Systems Portfolio in place and being maintained. PAS Printer Replacement project underway. New PAS Hardware project nearing completion. Infrastructure systems roadmap developed. regular reviews with Chantry Vellacot now in place. Sept 09: New PAS hardware installed. The change over to the new box will be early in October 2009. Nov 09: New PAS hardware working. Internal audit programme now in place. NIMM Assessment workshop planned for 26/11/09. Mar 10: Referring to Action Plan 2. Risk 748 closed, risk 749 Printer rationalisation project 3. Virtualisation plan in place, June 10 implementation. 4. IT Roadmap developed. 5. Review completed (risk 745) changed to tolerate. 6. Completed 7. Due to take place Q1 2010. Risk reduced to Medium.	?	?	Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield

ID	Title	Description	Rating (current)	Risk level (current)	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 Lodestone and Inhealth.	6	MED	26-Mar-2009	15-Jun-2010	1. Re-negotiation of contract for a 10 year period with Lodestone. 2. Negotiate a contract extension for 18 months with Inhealth. 3. Joint management boards to review quarterly.	Mar 09: Contracts have been reviewed by the Trust's legal team to ensure minimal risk financially and to limit other risks. Due diligence has been completed. July 09: 'In Health' have renewed the contract for 18 months, however there is still a chance of other factors leading to a break in the service. Risk Tolerated Mar 10: The Trust will retender for above contract in 2010. Risk returned to Treat	?	?	Executive Director: Valerie Howell Contacts: Catherine Townsend

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1B)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions	6	MED	12-Mar-2008	17-May-2010	Require more isolation facilities or ability to provide an isolation ward when necessary (at trigger point) whilst striving to without affecting normal business and national targets like 98% and 18 weeks. Aug 09: Assimilated 'Care Quality Commission' visits to wards are being carried out across the trust by Caroline Becher (Chief Nurse) and Linda Fairhead (Consultant Nurse - Infection Control) Nov 09: Ongoing. Root Cause Analysis undertaken for new MRSA bacteraemia and C Diff.	May 2009: Ongoing work by Infection Control Team, Hotel Services and vigilance of all staff. Aug 09: Present MRSA Bacteraemia rates are low and below trajectory. Any issues raised by the assimilated visits are discussed with and actioned by the Ward Manager. Sept 09: Risk level reduced to High due to evidence that MRSA bacteraemia hospital acquired infections have significantly reduced (none for 175 days). Nov 09: Care Quality Commission 'spot check' visit completed and no areas of concern were noted by the inspectors. We remain compliant. We remain within trajectory for National Targets. Mar 10: MRSA and C diff figures remain on trajectory. All areas now have isolation facilities. Assimilated CQC ward visits continue by the Chief Nurse and Consultant Nurse Infection Control. Risk reduced to medium	3	LOW	Executive Director: Caroline Becher Contact: Linda Fairhead

ID	Title	Description	Rating (current)	Risk level (current)	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
907	Service failure- Swine Flu Pandemic	The Swine Flu Pandemic may cause a high number of staff sickness and absence and a high number of patients (adult and paediatric) requiring hospital admission and intensive care consequently there is a risk of service failure. The key issues will be: (a) Service provision and performance targets (Business continuity) (b) Suboptimal patient care (c) Staff fatigue (d) Demand and capacity (e) Ethical considerations (f) Supply chain failure At risk: Service failure; Reputation; National targets; Statutory duty	3	LOW	16-Sep-2009	4-Jul-2010	1. Local areas to have Business Continuity Plans in place. 2. Main Pandemic Flu Plan supported by local area Flu plans. 3. Local ethical framework to be developed. 4. Escalation plans to meet the demand of Winter planning, bed remodelling and swine flu admissions. Dec 09: On going day to day management and adjustments to flu plan. Impact monitored daily, in house, as well as by the PCT/SHA.	Nov 09: Flu plans and the Trust's overall preparedness continue to be developed. The recent planning assumptions indicate a lower clinical attack rate and lower staff absence rate, but over a prolonged period ie Oct to May and not 15 weeks. Dec 09: Patient numbers have been below the expected level. It is still unknown as to how the disease will develop. Remains high risk due to this and winter pressures. Mar 10: Experience throughout the Winter months both locally and across the UK has shown significantly lower than expected levels of infection from the Swine Flu virus. The Swine Flu Hotline is now closed and D of H statistics indicate low levels of infection and ,since Christmas, high vaccination figures for designated risk groups. The risk is at present low.	3	LOW	Executive Director: Valerie Howell Lead Manager: Valerie Howell Key Personnel: Valerie Howell Contact: Valerie Howell from Jan 10

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887	Loss of Person Identifiable Data	There exists the possibility of the loss of PID as a result of a lack of understanding from staff regarding personal responsibility for data and information governance (IG). At risk: Patient safety, Financial Loss, Reputation, Failure of Statutory duty.	3	LOW	17-Jul-2009	7-Jul-2010	Develop and instigate mandatory IG training that demonstrates and promotes adherence to trust policy and legislation	Nov 09: Only encrypted memory sticks are to be used in the Trust. All others have now been banned and staff have been informed by Aspire (paper and electronic) and their managers. Port control is being tested. Training is now mandatory (2 year cycle) for information governance and will be completed by the end of Jan 2010. Mar 10: Port control implemented, Information Governance training nearly completed for all staff, encrypted memory sticks available and all laptops encrypted. Risk now low.	6	MED	Executive Director: Mike Baxter Key personnel: Robin Gammon, Alex Williams Lead: Robin Gammon Contact: Alex Williams, Tracy Street
Tolerate: Accept the risk at its current level of risk											
848	Financial loss due to uninsured claims	Uninsured losses in excess of £100,000, particularly associated with claims preceding NHSLA insurance arrangements.	12	HIGH	20-May-2009	11-Jun-2010	Solicitor to undertake investigation and develop a defence case covering one particular area of risk. Claims will be managed on a case by case basis.	Sept 09: No change. Dec 09: 'Defence' investigation due to commence Jan 2010. CM to liaise with the solicitor. Mar 10: Awaiting report from Facilities concerning asbestos review undertaken by outside consultancy.	9	HIGH	Executive Director: John Headley Lead: Colin Matthew, John Headley Contact: Colin Matthew

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745	IT: Over reliance on key individuals with specialist knowledge.	The Trust has a small number of experienced site-based staff, who look after the infrastructure systems, only two or three of whom have a deep knowledge such as that required to recover from a major outage.	6	MED	10-Jan-2008	24-Aug-2010	1. Recruit to vacant posts. 2. Review IT department organisation structure and roles/responsibilities. 3. Identify new roles and prepare business cases and recruit. 4. Knowledge sharing across department. 5. Create and maintain robust process and procedures documents for supporting all systems. 6. Develop central register of 3rd party support details. (IT Systems Portfolio) 7. Establish regular External/Internal Audit reviews. June 08: New mitigating action is for MDA to prepare a business case for additional technical staff.	June 08: Outcome of merger discussions has changed the proposed mitigating action, also likely repatriation of HIS technical services to Trusts will affect the outcome. Sept 08: Awaiting TUPE transfer of HIS staff back to Trust then business case will be prepared for additional staff. Jan 09: Now a Corporate risk Feb 09: No further progress. May 09: Awaiting recruitment of the Director of Finance and Information. Then take forward discussion and subsequent business case regarding additional IT staff. Sept 09: Director of Finance in post Nov 09: Internal sharing of knowledge is being managed within the department. The role of Maxwell Freer has been amended to Networks and Systems Manager. Risk now tolerated. Mar 10: No changes, the risk remains tolerated	?	?	Executive Director: John Headley Manager: Robin Gammon Contact: Laura Ellis-Philip, Margaret Broomfield