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

TRUST BOARD
30th June 2011

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 23rd June 2011, and highlights that since 15th April 2011: • Zero risks have been added • Two risks are awaiting Trust Executive Committee approval • One risk where the risk level has changed • Zero risks with a change to the treatment plan • Two 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, Head of Patient Safety On behalf of, Suzanne Rankin, Chief Nurse
Date:	23rd June 2011
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
30th June 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 27th May 2011. The next meeting is 24th June 2011.

Risks awaiting Trust Executive Committee Approval

Title	Division	Risk Type	Description	Action Plan	Principal objectives	Rating	Responsibility Owners
Underperformance of CIP Programme in 2011/12		CORPORATE	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	A full review of the CIP programme, including projects under the Programme Management Office (PMO) to be carried out after Month. Detailed CIP meetings to take place between executive directors and those divisions with significant forecast shortfalls. Weekly executive finance meetings to scrutinise CIP plans and to measure progress on a weekly basis. Contingency of £2m to be found to assist in covering any potential shortfall. Incentives for CIP over-performance to be confirmed.	TREAT	HIGH 12	Executive Director: John Headley Key Personnel: Valerie Bartlett; Robert Jeffries; Sarah Davis

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Title	Division	Risk Type	Description	Action Plan	Principal objectives	Rating	Responsibility Owners
The use of escalation beds Trust wide compromises patient safety privacy and dignity.		CORPORATE	Significant capacity issues affecting both hospitals which has meant keeping escalation beds open (often in inappropriate environments for our patients) having to cancel many routine procedures for other patients. This represents poor patient experience –it also has an impact on the Trust finances and external targets.	Immediate actions include: • Making sure patients are accommodated in the right place, and not in inappropriate 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.	TREAT	HIGH 12	Exec Director: Suzanne Rankin Lead Manager: Tony Ranzetta

Existing Risks where the risk level has changed since 15h April 2011

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	The NPSA issued a 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.	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 Friday the 6th May 2011. **June 11: Automated system now devised. Implementation now being planned. To go live July 2011**.	HIGH 12	HIGH 8	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.

Risk with a changed treatment plan since 15th April 2011

None

Risk closed since 15th April 2011

ID	Title	Description	Risk level	Opened	Closed date	Reason
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.	MED	20-May-2009	7-Jun-2011	*Previous progress held on paper by the Quality Department - R R section.* 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 **June 11: RISK CLOSED. A new risk for 2011/12 being considered.**
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*	MED	12-Oct-2010	6-May-2011	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. **May 11: Risk now being managed. RISK CLOSED.**

		Notification Form.				

Summary of Corporate Risks as at 16th June 2011

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risks							
1147	The use of escalation beds Trust-wide compromises patient safety, privacy and dignity.	HIGH	12	TREAT	12-Jun-2011	12-Jul-2011	Executive Director: Suzanne Rankin Lead Manager: Tony Ranzetta
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	HIGH	12	TREAT	12-Mar-2008	30-Jun-2011	Executive Director: Valerie Bartlett Lead Manager: Tony Ranzetta
832	Loss of income-Contracts. (BAF 3.4)	HIGH	12	TREAT	26-Mar-2009	30-Jun-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-Jun-2011	Executive Director: Valerie Bartlett Lead Manager: Tony Ranzetta
1072	Discharge process has identified risks to vulnerable patients	HIGH	12	TREAT	2-Sep-2010	4-Jul-2011	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	14-Sep-2011	Lead Manager: Charlotte Freeman Key Personnel: Wendy Pulling and Vijay Gautam
1129	30 day readmission rate	HIGH	12	TREAT	31-Mar-2011	11-Aug-2011	Lead Manager: Mike Baxter
1130	Lack of assurance of robust adult safeguarding procedures	HIGH	12	TREAT	31-Mar-2011	4-Jul-2011	Executive Director: Suzanne Rankin Key Personnel :Vanessa Avlonitis & Susan Brown
1112	Failure to act on radiological imaging reports resulting in missed diagnosis	HIGH	8	TREAT	2-Feb-2011	20-Jul-2011	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.
1113	Fraud and Corruption	HIGH	10	TREAT	2-Feb-2011	30-Jun-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	9	TREAT	12-Oct-2010	3-Aug-2011	Executive Director: John Headley Lead manager: Tracy Street
1083	Corporate lack of Trust Social Services worker post for Paediatric services	MED	6	TREAT	21-Sep-2010	2-Jul-2011	Executive Director: Suzanne Rankin Lead Manager: Jacqui Rees
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	11-Aug-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down

Summary of Corporate Risks as at 16th June 2011

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	30-Aug-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	11-Aug-2011	Executive Director: Valerie Bartlett Lead Manager: Hugh Jelley
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	4-Aug-2011	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	MED	6	TREAT	27-Oct-2008	13-Jul-2011	Executive Director: Suzanne Rankin Lead Manager: Jill Down
837	Delay in Psychiatric assessment - A & E and MAU	MED	6	TREAT	9-Apr-2009	9-Jun-2011	Executive Director: Valerie Bartlett Lead Manager: Hugh Jelley
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	11-Aug-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	16-Nov-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	23-Jun-2011	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 23rd June 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	30-Jun-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. **April 2011. Action plan launched to recover 4 hour standard (94.9% against 95%) including 30 day improvement plan re discharges and A&E flow.** **Revised capacity plan being developed for 26 May to ensure delivery of 95th percentile for June onwards with current activity being validated as the Trust is within 9 patients of achieving the standard.**	*All previous updates held on paper by the Quality department.* March 11: No change **May 11: Overall A&E performance has moved from 94.2% to 94.9% in the last two weeks in part due to reduced activity but also to both the focus on and a real increase in discharges. Current trajectory is on target to deliver 96%. The number of breaches in April 2011 mean that the Trust cannot achieve 98% performance in St Peters Hospital alone and so has failed its internal target for the quarter. Regarding 95th percentile for elective admissions April performance will not be known until 19 May 2011.**	4	MED	Executive Director: Valerie Bartlett Contact: Tony Ranzetta

Corporate Risk Register as at 23rd June 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	30-Jun-2011	*Previous Action Plan/s held on paper in the Quality department.* Jan 11: Action Plan as before plus additional work on AD Operations and Deputy Chief Nurse to assure compliance with single sex accomodation requirements. **May 11: Seek buyout of most local challenges (£1.4m for Surrey). Actions through Divisions re two new local challenges - particularly OP procedures. Briefing for TEC planned for June 2011. Second NWS review of FSS planned for July 2011.**	*All previous updates held on paper by the Quality department.* 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. **May 11: FSS prior authorisation embedded. Internal referrals now also sent to Thames Medical triage service - currently auditing. Contract Heads of Agreement awaiting signature by NHS Surrey.**	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-Jun-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.* March 11: Work being taken forward as part of newly formed PMO. **April 2011 Urgent Care Improvement programme formally launched by chief executive with one workstream being reduction of both admissions and readmissions, a second being the development of 17 ambulatory pathways to reduce admissions by 10-15%. Admissions have reduced with step changes in both June 2010 and December 2010 that are being investigated to see if these are long term sustainable or incidental**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Tony Ranzetta

Corporate Risk Register as at 23rd June 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	4-Jul-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 **May 11: Streamlining Discharge Programme established with workstreams focused on medium to long term improvment activity multidisciplinary training, review of discharge lounge facility, e-prescribing, documentation(SAP, HNA, DSTs), working with partner agencies. Training programme to commence June 11. Improvement of operational discharge management now a project within the Unscheduled Care Performance Improvement Programme with an operational lead supported by senior nursing and medical leadership focused on improved pathways, ward and team communication, effective clinical decsion making, taking personal responsibility for completion of discharge related tasks and enagagement with pharmacy.**	*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 Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis cc Claire O'Brien

Corporate Risk Register as at 23rd June 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	14-Sep-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.**	May 2011: This risk is currently being reviewed by the Chief Nurse and management team with respect to broadening the risk. **June 11: Risk remains at the same level.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Charlotte Freeman

Corporate Risk Register as at 23rd June 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 reputation.	8	HIGH	2-Feb-2011	20-Jul-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 Friday the 6th May 2011. **June 11: Automated system now devised. Implementation now being planned. To go live July 2011.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Mike Baxter.

Corporate Risk Register as at 23rd June 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	30-Jun-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. May 11: No change**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore

Corporate Risk Register as at 23rd June 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.	9	HIGH	12-Oct-2010	3-Aug-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. **June 11: 10/06/11 Approximately 500 staff still to be trained. Active campaign ongoing, closes 24th June, deadline for submission 30th June 2011. Optimistic outlook at present.**	3	LOW	Executive Director: John Headley Lead manager: Jane White

Corporate Risk Register as at 23rd June 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1129	30 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	11-Aug-2011	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.**	3	LOW	Lead Manager: Mike Baxter
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 pollicy, procedures and practice within Divisions. First action to be Divisional Review with assessment and improvment 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	12	HIGH	31-Mar-2011	4-Jul-2011	March 11: Review in detail adult safeguarding concerns and processess 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.	**May 11: A scoping exercise is being undertaken to ascertain and enable an accurate estimation of training requirement and associated resourcing.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis

Corporate Risk Register as at 23rd June 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

Corporate Risk Register as at 23rd June 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	11-Aug-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: . 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. **May 2011: QRP high level summary continues to indicate no red or amber risks for the Trust from CQC perspective. Owners of standards have been reminded of the importance of ensuring ongoing review of Trust evidence and that this is loaded onto the Trust database with quarterly review with the standard owner. The Trust aim is to ensure all evidence is loaded onto the Trust database by the end of May with development of action plans where appropriate.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down

Corporate Risk Register as at 23rd June 2011

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	30-Aug-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.**	*All previous updates held on paper by the Quality department.* 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. **June 11: The risk and action plan were fully discussed at the Complaints Monitoring Group on 6 May 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 29 July 2011.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers.	6	MED	26-Mar-2009	11-Aug-2011	Negotiate a contract extension for 18 months with Inhealth. Joint management boards to review quarterly.	*All previous updates held on paper by the Quality department.* 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. **May 11: Timetable for award is September 2011 with ITT to be published by June 2011. InHealth have agreed to a contract extension to cover the tender period mitigating the risk.**	3	LOW	Executive Director: Valerie Bartlett Lead Manager: Hugh Jelley

Corporate Risk Register as at 23rd June 2011

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	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 2010 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 23rd June 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	4-Aug-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.* **May 11:** **1. Sustained downward trend in qualified nurse vacancies (down from 16.2% in April '10 to 9.9% in March '11). Net qualified Nurse & Midwife headcount has increased by 45 over this period. 23 Band 5 candidates being processed following successful recruitment event held in April.** **2. 17 Overseas Nursing Programme candidates successfully completed course and now practising as registered nurses.** **3. Review of Ward establishments complete.** **4. 1 A&E Consultant commenced 14 March 2011 + 1 Bank Consultant in February 2011. Further advertisements for Consultant and middle grade positions open; 1 middle grade appointment made, awaiting start date. Enhanced medical bank rates extended to mitigate agency expenditure.** **5. Midwife vacancy rate will be c.5% once confirmed appoinments have commenced. Further recruitment in progress; applicants who are qualifying in September on reserve list in case of further vacancies arising.**	4	MED	Executive Director: Raj Bhamber Lead Manager: Jeremy Over

Corporate Risk Register as at 23rd June 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-Jul-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. **May 2011: The policy database shows 68% compliance of in date policies. Patient care and nursing procedures remain the highest numbers of policies out of date. An action plan is being worked through to address the shortfall.**	3	LOW	Executive Director: Suzanne Rankin Lead Manager: Jill Down

Corporate Risk Register as at 23rd June 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	21-Sep-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. **June 2011: In consultation with Psychiatric colleagues we have reduced the number of referrals forms from 3 to 2. This has made access simpler for staff and reduced risk of patient being referred inappropriately.**	2	LOW	Executive Director: Valerie Bartlett Lead Manager: Hugh Jelley

Corporate Risk Register as at 23rd June 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	11-Aug-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. **May 11: Latest national inpatient survey results (2010) indicate an improved position. Importance of national surveys need continued and sustained emphasis as Trust moves into the next survey period, sampling outpatients in May 11 and inpatients July 11. Corporate and divisional action plans in place.**	6	MED	Executive Director: Suzanne Rankin Lead Manager: Vanessa Avlonitis, Jill Down

Corporate Risk Register as at 23rd June 2011

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
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	16-Nov-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.** **May 11: No change**	*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 10: No change except that Kestral has opened. Plans to address Privacy and Dignity for the older person in January 2011. **May 11: Refurbishment complete. Need to be mindful of new critieria set by the Department of Health regarding Critical care, High Depedency, CCU and MAU areas.**	2	LOW	Executive Directors: Suzanne Rankin Lead Manager: Vanessa Avlonitis

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	23-Jun-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 **May 2011: No change**	3	LOW	Executive Director: John Headley Lead Manager: Miriam Moore