EAST KENT HOSPITALSUNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **30 OCTOBER 2014**

SUBJECT: **CORPORATE RISK REGISTER – TOP 10**

REPORT FROM: **CHIEF NURSE AND DIRECTOR OF QUALITY**

PURPOSE: **Information and discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This document provides the Board of Directors (BoD) with an update of progress as at 17 October 2014 with the top 10 risks on the Corporate Risk Register (CRR). The top 10 risks were last received by the BoD at the July 2014 meeting; the full register was reviewed by the Board in August. This report includes changes that occurred since the last Quality Assurance Board (QAB). The full register was last presented to the Risk Management and Governance Group (RMGG) on 23 July 2014; the top ten risks were reported on 27 August 2014. The financial risks were also reviewed at the June meeting of the RMGG and were reviewed by the Financial Investment Committee (FIC) in September. The top 10 risks were reviewed by the Integrated Audit and Governance Committee on 09 October 2014.

SUMMARY

There are four risks with an unmitigated risk score of 25 and five with a score of 20. The top nine include, the reputational risk associated with the CQC inspection report, the internal financial efficiency programme; the deterioration in A&E performance standard and the potential risk to patients waiting longer than four hours; the external financial risk associated with CCG demand management, contract negotiations and financial challenges; the increased risk to patient safety associated with inefficient clinical pathways/patient flow resulting in extra beds; the consistent poor performance in the staff survey results and staff feeling they are not engaged in decision-making that affects them; delays to cancer treatment due to closure of the Aseptic Service and the internal financial operations performance targets. The Aseptic Service has been further affected by water damage to the area and this aspect added to the risk register. The mitigation actions have not affected the pre- or post mitigation scores. The risk associated with the findings of the CQC report is the number one risk affecting the organisation currently.

The emerging risks were discussed at the Management Board (MB) and the Quality Assurance Board (QAB) in October; these are further explored in the attached paper. The decision taken at that time was not to add these risks onto the register but to maintain a close overview of any significant changes, which may affect that decision.

New	Two	• Trust response to the recently published PHSO report "Time to Act – severe sepsis: rapid diagnosis and treatment saves lives" and the non-compliance with standards following audit. • Staff survey results and engagement plans with staff
Reduced	None	
Increased	None	
Substantially changed	Two	• HCAI – Clostridium difficile infections (CDI) remain above trajectory; the surgical division have exceeded their targets for the year • A&E performance is still not being maintained against the 4-hour standard

Removed	Three	• Spencer Wing (Healthex Group) purchase – the profits for the last financial year and for the first quarter are being sustained • Trust response to the Reports into the provision of surgical services by the Royal College of Surgeons and the Health Education KSS • Interim centralisation of the management of all East Kent high risk and emergency general surgery at Kent and Canterbury Hospital
Emerging	Six	• Orthopaedic and other demands on urgent care pathways from West Kent patients • Automated NHS number generation in maternity • A higher standardised mortality rate than the national average for the age range 18-49 years • Pressures on the Children's Safeguarding Team due to staffing issues • Oncology resource and cover arrangements with an external NHS Trust. This provision is not meeting the current SLA • Management of potential Ebola infected patients

Discussions have taken place with the Trust Secretary on the improved integration of the risks outlined within the Board Assurance Framework and the Corporate Risk Register.

RECOMMENDATIONS:
The Board is asked to review the paper and associated attachments and decide if they are a true representation of the top 10 risks affecting the Trust currently.

NEXT STEPS:
A revised risk register will be presented to the October QAB and the emerging risks were reviewed at the Management Board on 15 October 2014.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:
The Strategic objectives and BAF will ultimately drive the Annual Governance Statement, which represents the Trusts' ability to identify and manage risks effectively. Failure to demonstrate a consistent approach to the mitigation and control of risks can impact considerably on the effective delivery of the Trust's strategic and annual objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:
There is an integral link to the Board Assurance Framework that runs through all the risks on the risk register; there is a specific link to A03.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
The attached risk register is a distillation of the top 10 risks affecting the Trust and the mitigating actions in place.

FINANCIAL IMPLICATIONS:
Actions to mitigate certain risks have considerable impact on Trust expenditure; financial risks are now quantified in terms of single or cumulative costs. Failure to mitigate some risks will also result in financial loss or an inability to sustain projected income levels.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust could face litigation if risks are not addressed effectively. The aim of the Public Sector Equality Duty is relevant to the report in terms of the provision of safe services across the nine protected characteristics.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES Not applicable
BoD ACTION REQUIRED: **(a) to discuss and determine actions as appropriate**
CONSEQUENCES OF NOT TAKING ACTION: The Trust will continue to face unmitigated risks which may result in a worsening of the current position.

Summary

1.1. Explanation

This document provides the Board of Directors (BoD) with the top 10 risks on the corporate risk register as at 17 October 2014. The full register was last presented to the Board at the August 2014 meeting, the top ten risks were reported at the meeting on 25 July 2014. The full Corporate Risk Register was received by the Risk Management and Governance Group (RMGG) on 23 July 2014 and the top 10 risks were reported at the last meeting on 27 August 2014. This report includes changes that occurred since the August meeting and the meetings of the Management Board (MB) in September and October 2014. The financial risks were presented to RMGG at the June meeting and last discussed at the FIC on 28 January 2014. There are changes to the financial risks associated with the recent signing of the capped PbR contract for 2014/15 in terms of the external risks as currently outlined in the Corporate Risk Register. The internal risks around financial efficiencies, their controls and the cost improvement programmes remain. The external risks associated with increased clinical activity over the current contractual performance will require revision. This will be managed by the Finance and Investment Committee (FIC).

The Corporate Risk Register outlines descriptions of the risks, mitigating actions, residual impact following the action, and cumulative outline of action taken. Progress is being made across each area of risk in pursuing the necessary actions to control and mitigate the risks. Risks associated with Health and Safety legislation are as indicated on the register.

The 10 highest areas of risk are:

Rank	Risk Number	Summary
1	57	CQC inspection – quality, safety, financial and reputational risk
2	34	A&E targets and emergency pathways
3	27	Internal - Financial Efficiency Improvements and Control
4	29	External - CCG Demand Management, Contract Negotiations and Financial Challenges
5	3	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient flow
6	52	Clinical and patient safety risks associated with the delayed implementation of the PACS/RIS
7	59	Poor staff survey results and evidence of staff engagement
8	54	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service
9	30	Internal – financial operational performance targets
10	4	Achieving quality standards/CQUINS

1.2. Significant changes to the Register since September 2014 – Two

1.2.1. **Risk 15 - Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates.** Currently there is one case of MRSA bacteraemia assigned to the Trust to date during this financial year. Two cases were reported; both pre-48 hour.

The Trust target for C. difficile for 2014/15 is 47 cases, which is in line with previous targets. There have been 34 reported cases of C difficile within the new financial year at the time of this report. This equates to seven cases above trajectory for this financial year. The UC&LTC Divisions is in line with trajectory; the Surgical Division and the Specialist Division are ahead of target; the Surgical Division has reported 13 cases against a total trajectory of 12 for the year. NHS England has revised their objectives and guidance for C. difficile infections (CDI) for 2014/15. The key change is the linking of each CDI with identifiable lapses in care. Where there is no link with identifiable lapses in care, there is a proposal that such cases are not considered when contractual sanctions are being calculated; agreement for exclusion must be agreed with the co-ordinating commissioner. A serious incident was raised recently due to three post 72 hour incidents of C difficile infection, all linked epidemiologically in time and place to Minster Ward. Actions implemented to date include daily visits by Infection Prevention and Control (IP&C) Clinical Nurse Specialists and daily hand hygiene audits.

There was no linked ribotyping on the C diff cases reported on Cambridge M2 and this PII has not been reported as a serious incident. Actions taken were daily visits by IP&C Clinical Nurse Specialists are reviewing all patients with diarrhoea. A Diarrhoea Competency Assessment Tool is being developed by the ward staff.

A recovery plan is in place including the implementation of Hydrogen Peroxide vapour system (HPV) for high level disinfection of clinical areas Trust wide as appropriate. In addition, the IPCT are implementing the HOUDINI protocol to improve the management of urinary catheters with regard to strict criteria for insertion and removal which will be audited.

1.2.2. **Risk 34 - A&E performance targets** – This risk is also linked to risk 47 “lack of a whole systems response to activity pressures” and to risk 3 “patient safety risks associated with inefficient clinical pathways and patient flow”.

The Trust failed to meet the four-hour standard for April, May and June 2014, with performance at 94.7%, 94.5% and 93.8% respectively, which resulted in a failure for quarter 1. The Trust was again non-compliant with the four-hour A&E standard in July 2014 at 92.44%, it did meet the standard in August at 95% but was non-compliant against the standard for September at 92.9%.

The Action Plan is progressing with the majority of the actions rated as amber or green. There are no red actions currently. Progress has been made against the seven key headings as follows:

Governance and Policy:
The A&E Performance meeting is now well established with the Emergency Care Programme Board having a planned delayed implementation date until October 2014 due to annual leave. The review of the Standard Operational Plan for the Emergency Floor is scheduled for presentation to the Clinical Advisory Board with Dr Bhargava working closely with the Clinical Leads and Divisional Medical

Directors to ensure optimal pathways have been included. This also includes escalation and full capacity protocols.

Pathways:
The Integrated Discharge Team project will be implemented in October as part of the Urgent Care Pathway transformation which incorporates rapid assessment and ambulatory care. The Division is also liaising with other Divisions to review paediatric pathways, the implementation of a SAU at WHH and QEQMH and diagnostic pathways.

Workforce:
The job planning of ED Consultants to work extended hours into the evenings and weekends is being implemented on an "ad hoc" basis funded by Surge Resilience Monies pending the development of a medical staffing business case, which will support a three year strategy for increasing the number of ED consultants. Ongoing recruitment to cover the gaps in the Speciality Doctor rotas is being managed through UK and overseas recruitment. The training and development programme for Speciality Doctors is in progress and should improve recruitment and retention.

Clinical Leadership and Engagement:
The ED Consultants and Matrons are actively involved in reviewing the A&E breaches to understand and address the reasons for delays in the patient pathways. The Action Plan has been shared with all staff in ED by email and is displayed in the departments. The ED Matrons have also discussed the Action Plan at their departmental staff meetings to ensure that all staff have ownership of the plan and are involved in progressing the actions.

The Action Plan has been linked to the Surge Resilience funding bids, with the Integrated Discharge Team, Surgical Assessment Unit and additional A&E Consultant hours in the evening and weekends to provide senior leadership and to support patient flow.

Communication and Information:
The deployment of the TV screens in ED will provide waiting times for the departments and information on local urgent care services. The Emergency Medicine report pack is developed and reviewed as a regular agenda item on the A&E Business Meeting agenda and the Emergency Care Dashboard is in the final stages of development.

1.3. **Risks decreased in September 2014 – None**

1.4. **Risks increased in September 2014 - None**

1.5. **Risks removed from the Register in September 2014 – Three**

1.5.1. Spencer Wing (Healthex Group) purchase – the profits for the last financial year and for the first quarter are being sustained. The risk will continue to be monitored by the FIC as part of the finance risk register.

1.5.2. Trust response to the Reports into the provision of surgical services by the Royal College of Surgeons and the Health Education KSS (HEKSS). This risk will continue to be monitored by the Surgical Division and the risk reviewed in light of any further emerging concerns.

1.5.3. Interim centralisation of the management of all East Kent high risk and emergency general surgery at Kent and Canterbury Hospital. This risk did not materialise and will be reviewed in light of any changes to the Clinical Strategy.

1.6. **Risks added to the Register in September 2014 – Two**

1.6.1. **Risk 58 - Effective diagnosis and management of sepsis**

The Parliamentary and Health Service Ombudsman (PHSO) published a report into the wide national variations in the management of severe sepsis nationally. The report "Time to Act – severe sepsis: rapid diagnosis and treatment saves lives". The Trust has participated in the recent National Severe Sepsis and Septic Shock audit (A&E), the results of which were expected in May 2014. The report was published in September 2014 for the QEQMH and the WHH. There was deterioration in performance at both sites from the previous audit in 2011. The Trust is not fully compliant with the standards for the treatment and management of severe sepsis published by the College of Emergency Medicine. A recommendation from the PHSO's report is that these increased risks should be reflected in the Trust's risk register.

The data collection for the National Confidential Enquiry into Patient Outcome and Death Sepsis Study also commenced in May 2014. The study aims to identify and explore avoidable and remediable factors in the process of care for patients with known or suspected sepsis. The Trust will be participating in this study; the results are not however expected until autumn 2015. In the interim, the Trust is identifying professional activities (PA) time for a designated clinical lead for sepsis and is in the process of reviewing the RCAs undertaken over the past two year period as a thematic analysis to indentify gaps in the clinical pathways of care. The clinical audit programme for the Trust for the 2014/15 financial year is being updated by the divisions to take account of this Report and the results of the thematic analysis, when this is complete. This risk was initially discussed at the RMGG in May and since this meeting, the inaugural meeting of the multi-disciplinary Trust Sepsis Collaborative has taken place. Planning and actions corporately and locally were identified and a date for the next meeting identified.

The unmitigated risk score is 16 and the post mitigation score is 8.

1.6.2. **Risk 59 - Risks to the achievement of the annual objective A03 relating to improving the overall score in the annual staff survey and embedding staff engagement into everyday practice in the Trust.**

There is an associated risk to improving the component scores that make up engagement in the Staff Survey against the 2013/14 performance and the Friends and Family Test element in the staff survey in relation to working / being treated at the hospital.

There is an associated programme led by the Director of HR as part of the CQC High Level Improvement Plan. The "We Care – delivering our cultural change" programme was initiated in September 2014. The project is broken down into three schemes that, when delivered together, will support the change to the organisational culture in the next 24 to 36 months. The plans cover the initial diagnostic work and other planned activity in the period until the end of March. Importantly the plans include the development of ideas from staff received as feedback to the CQC improvement plan. The plans will need to be further developed and extended following the appointment of our external partner and the completion of diagnostics.

Cultural change takes time and it will be important to, where possible, evidence to staff the impact of our early changes and assure the board of our delivery of key milestones. This will allow our staff to make a judgement as to whether the leadership of the organisation is committed to the change, is holding others to account for its delivery and have the resilience to sustain the approach in the midst of competing priorities.

The schemes identified are as follows:-

- The We Care work stream
- Workforce strategy work stream
- Improving engagement work stream

The We Care Steering Group will monitor delivery of the plan, through their monthly meetings, with regular reports to the Quality Board.

Local issues and actions will be monitored by Division through the quarterly FFT surveys and executive performance reviews.

Collaboration with our external partners to develop and agree overall programme progress "checkpoints", which will include feedback from front line staff and those involved in delivering the programme will take place. This will allow the identification of:-

- emerging issues to help the Executive Team identify positive and negative drivers for staff engagement and motivation;
- any of quick wins by which senior leadership can demonstrate listening and connection with front line staff;
- any changes required to the programme in response to feedback.

The success of this programme will be monitored by the Board through the production of a quarterly report, reporting against key milestones and outcomes, evaluating progress and making recommendations on changes as necessary.

The quarter 2 Friends and Family Test (FFT), which followed the publication of the CQC inspection report, saw a 10 per cent reduction, from 55% to 45% in the number of staff who would recommend the organisation as a place to work. It is likely that these scores will continue to decrease until this programme of work is fully embedded.

The unmitigated risk score is 20 and the post mitigation score is 12; this places the risk within the top 10 facing the Trust at this time and is linked with risk 57.

1.7. **Emerging risks**

1.7.1. Demand for the Orthopaedic service continues to increase with primary care referrals showing a significant over-performance on the current activity plan. Joint work with the commissioners and community Trust has proved that the increase in referrals is as a result of changes to community Orthopaedic provision and, as such, the Trust is implementing a revised triage process in order to redirect these referrals to the community Trust. Analysis has been conducted to identify GP Practices with a high referral rate per 1,000 population. This information has been shared with commissioners. There is an increased referral of patients requiring urgent treatment coming from West Kent, which is further affecting demand across the system. This patient cohort is of a high acuity and is more often admitted for further management and treatment. Consequently, arrangements for discharge are complicated by delayed assessment from Social Services and other agency support.

1.7.2. The provision of automated NHS numbers for newborns through the current maternity system is no longer fully functional. The Trust is planning for a replacement management system, so the risk will be mitigated once this is in place. In the interim however, the allocation of the unique number must be undertaken by clinical staff manually. This constitutes risk associated with human error and a delay in the accurate identification of newborn babies within the Trust. This risk is incorporated in the Divisional Risk Register for the Specialist Division.

1.7.3. A review of deaths occurring in patients from 18-59 age group was presented to the BoD and participants of the Sepsis Collaborative in September 2014. This analysis has identified issues around the timely diagnosis and treatment of the patients in the 18-49 age group specifically and in the recognition of sepsis. The Hospital Standardised Mortality Ratio (HSMR) is above the national average. Monitoring of patient outcomes is an integral component of the Sepsis Collaborative and patients with this diagnosis will be monitored as part of this programme. The Information Team are reviewing the patient level data and any additional issues such as site differentials in mortality or specific patient characteristics, which may place some patients at greater risk. A view will then be taken on the actions that need to be implemented.

1.7.4. There are increased activity and workload pressures being experienced by the Child Safeguarding Team. Until June 2104 there were three Child Safeguarding Advisors. Since then, despite early advertising of the vacancy, only two Advisors are currently in post. A secondment opportunity has been identified for a midwife and an RN Child to work within the team for a period of six months; this is to support the currently team and increase the staffing once the substantive post has been recruited. The CQC identified gaps in the training provision for level 3 compliance and this, with the current number of staff in post, is proving difficult to address. The training issue at level 3 is further compounded by the requirement for six hours of

face to face training over a three year period in future, in order to fulfil the changing scope of the intercollegiate requirements. There are two high profile and complex Serious Case Reviews, the evidence must be with the Panel by December 2014. Finally the Safeguarding Liaison Team, who were employed by the Community Health Trust have been moved into Universal Services. They are no longer supporting staff within A&E, NICU/SCBU or paediatric wards across the Trust. Consequently, ward staff and the Child Safeguarding team are covering this function until the risk can be highlighted to commissioners.

1.7.5. The Trust has a signed Service Level Agreement (SLA) with a local NHS Trust to provide the medical Oncology Service to the patients of East Kent. The Trust employs the speciality nursing provision to support the activity. The demand for specialist Oncologist input is currently not being provided in line with the SLA. This is affecting the timeliness of specialist medical input into diagnosis and on-going management of patients with cancer. The Medical Director will be writing to the current provider to ascertain the reasons for the gap in service being seen. The risk scores will then need to be calculated on the basis of the response and the mitigating actions proposed. The Specialist Services Division will continue to review the risk on their Risk Register in the interim.

1.7.6. The recent outbreak of the Ebola virus mainly affects three countries in West Africa: Guinea, Liberia and Sierra Leone. Around 8,300 cases and more than 4,000 deaths have been reported across these countries by the World Health Organisation. It is classed as a Viral Haemorrhagic Fever and the Trust has a draft policy aligned with national guidance, risk assessment algorithm and referral pathways available on SharePoint. This is the largest known outbreak of Ebola. So far, there has been one imported case of Ebola in the UK. Experts studying the virus believe it is highly unlikely the disease will spread within the UK; however, the Trust has seen three patients admitted with a possible diagnosis of Ebola Virus Disease. All three cases were negative but the admissions have identified issues with staff awareness of training, the availability of personal protective equipment (PPE) and the testing of the consistent safe use of PPE. There are no plans to screen people travelling into Folkestone via the Eurotunnel; there remains the possibility of screening via the main airports and Eurostar passengers. The Trust has an arrangement with Royal Free London NHS Foundation Trust to transfer any confirmed patients with Ebola Virus Disease to a specialist unit.

2. Risk Register and impact on the Annual Governance Statement

2.1. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Kent Hospitals University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2.2. The gaps in controls identified for the revised performance risks will impact on the Annual Governance Statement for 2014/15 and the internal systems currently in place to control and manage risk effectively.

3. The Board are requested to:

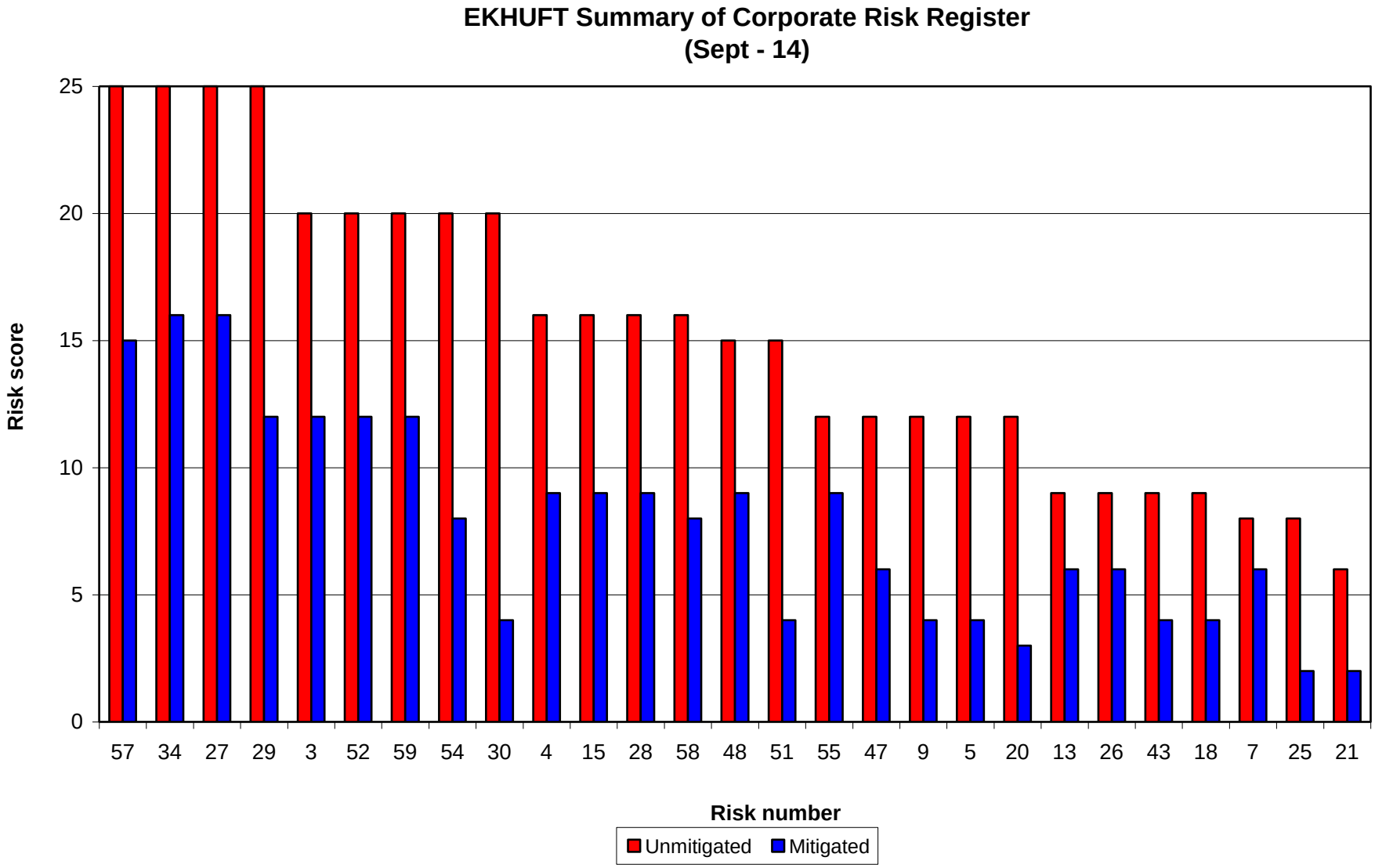
3.1. Note the report, discuss and determine actions as appropriate and approve the revised risk register.

4. Pre and Post Mitigation Scores

Highest risk post mitigation

Current order	Risk number	Unmitigated	Mitigated	Description	Last Reviewed	Review Contact
1	57	25	15	Qaulity, safety, finance and reputational risk to the Trust as a consequnce of the publication of the CQC inspection report	Aug-14	Julie Pearce
2	34	25	16	A&E performance targets	Apr-14	Giselle Broomes
3	27	25	16	Internal - Financial Efficiency Improvements and Control	Jun-14	Mark Austin
4	29	25	12	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Jun-14	Mark Austin
5	3	20	12	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient	Mar-14	Julie Pearce/Jane Ely
6	52	20	12	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	Aug-14	Mary Tunbridge
7	59	20	12	Poor staff survey results and evidence of staff engagement	Sep-14	Sandra Le Blanc
8	54	20	8	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service	Apr-14	Mary Tunbridge/Obafemi Shokoya
9	30	20	4	Internal - Operational Performance Targets	Jun-14	Jeff Buggle
10	4	16	9	Achieving quality standards/CQUINS	Mar-14	Helen O'Keefe
11	15	16	9	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Mar-14	Sue Roberts
12	28	16	9	External - Cost and Income Pressures including Technical Changes	Jun-14	Mark Austin
13	58	16	8	Effective diagnosis and management of sepsis	Sep-14	Michelle Webb
14	48	15	9	Patient experience concerns following transition of current Transport Service to a new national provider	Dec-13	Finbarr Murray
15	51	15	4	Business continuity and disaster recovery solutions for Trust wide telephony	Mar-14	Andy Barker
16	55	12	9	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Apr-14	Jane Ely
17	47	12	6	Winter planning and capacity management	Jan-14	Jane Ely
18	9	12	4	Loss of clinical reputation due to unmitigated patient safety risks	Oct-13	Michelle Webb
19	5	12	4	Failure to meet 18 weeks RTT	Mar-14	Marion Clayton
20	20	12	3	Compliance with Information Governance Standards	Mar-14	Michael Doherty
21	13	9	6	Age and Design of Trust constraint EKHUFT being top 10 in England	Apr-14	Finbarr Murray
22	26	9	6	Profile and effectiveness of the clinical audit function	Jan-14	Robin Ufton
23	43	9	4	Embedding Divisional Quality Governance	Jan-14	Helen Goodwin
24	18	9	4	Complexities of Managing the Market	Jun-14	Rachel Jones
25	7	8	6	Incomplete health records (risk re-named and re-scored August 2010)	Dec-13	Marc Farr
26	25	8	2	Management of complaints and patient experience	Mar-14	Sally Smith
27	21	6	2	Blood transfusion process - vulnerable to human error	Mar-14	Angela Green

5. Highest risk post mitigation



Appendix 1 - scoring methodology

Risk Scoring Matrix (Financial values have been added to these levels)

CONSEQUENCE / IMPACT FOR THE TRUST	
LEVEL	**DETAIL DESCRIPTION**
1	Negligible - no obvious harm, disruption to service delivery or financial impact. Reputation is unaffected.
2	Low - The Trust will face some issues but which will not lower its ability to deliver quality services. Minimal harm to patients; local adverse publicity unlikely; minimal impact on service delivery. Financial impact up to £1 million non recurrent/one off or up to £2 million over 3 years.
3	Moderate – The Trust will face some difficulties which may have a small impact on its ability to deliver quality services and require some elements of its long term strategy to be revised. Level of harm caused requires medical intervention resulting in an increased length of stay. Local adverse publicity possible. Financial impact between £1 million and £3 million non recurrent/one off, or between £2million and £ 6million over 3 years.
4	Significant – The Trust will face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long terms strategy. Major injuries / harm to patients resulting in prolonged length of stay. External reporting of consequences required. Local adverse publicity certain, national adverse publicity expected. Likelihood of litigation action. Temporary service closure. Financial impact between £3million and £5million non recurrent/one off or between £6 million and £10million over 3 years.
5	Extreme – The Trust will face serious difficulties and will be unable to deliver services on a daily basis. Its long term strategy will be in jeopardy. Serious harm may be caused to patients resulting in death or significant multiple injuries. Extended service closure inevitable. Protracted national adverse publicity. Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.

LIKELIHOOD OF RISK CRYSTALLISING	
LEVEL	**DETAIL DESCRIPTION**
1	Rare - may occur only in exceptional circumstances. So unlikely probability is close to zero.
2	Unlikely - could occur at some time although unlikely. Probability is 1 - 25%.
3	Possible – reasonable chance of occurring. Probability is 25 – 50%.
4	Likely – likely to occur. Probability is 50 – 75%.
5	Almost Certain – Most likely to occur than not. Probability is 75 -100%.

		Impact				
		1	**2**	**3**	**4**	**5**
Likelihood	**1**	L	L	M	H	H
	2	L	L	M	H	E
	3	L	M	H	E	E
	4	M	M	H	E	E
	5	M	H	E	E	E

E	Extreme Risk - immediate action required
H	High Risk - senior management attention required
M	Moderate Risk - management responsibility must be specified
L	Low Risk - manage by routine procedures

Top 10 corporate risks

Ranked position	Risk type	Risk No.	Risk Name	Source of Risk	Risk Description	Health & Safety Related?	Site	Date Added	Governance level	Consequences (current)	Likelihood (current)	Risk rating (current)	Executive Lead	Target Date for Completion	Controls in place	Additional Actions/Progress	Consequences (mitigated)	Likelihood (mitigated)	Risk rating (mitigated)	Movement
1	Quality and Operations	57	CQC inspection March 2014	Care Quality Commission	The reputational, quality, safety and financial consequences associated with the CQC's published report into the Trust	N	TW	Aug-14	Clinical/Operational	5	5	25	Chief Executive	Mar-17	Externally facilitated workshop with CCG leads has taken place as a starting point to build better relationships with commissioners. The High level action plan was sent to the CQC on 23 September 2014. There has been divisional engagement with the more detailed, local action plans that are required. The Trust is in Special Measures and subject to a monthly review meeting with Monitor. A series of diagnostic programmes have commenced; these include divisional governance and data quality. A Ward to Board governance review is being scoped and then is out for tender in October 2014.	A series of engagement events with staff have taken place, but more work of staff engagement will be required;; this is being aligned with the We Care programme developments. An interim Improvement Director has undertaken an initial review of the Trust and an Programme manager identified to follow through on the HLIP. A formal Improvement Director has been appointed by Monitor and she has overseen the publication of the NHS Choices Actin Plan on their website.	5	3	15	↔
2	Finance	27	Internal - Financial Efficiency Improvements and Control	Finance and Investment Committee	Trust fails to meet its savings target for 2014/15 and into 2016/17 and without action with Trust will miss its CIP target by more than £5millionWorking Capital may be insufficient to support Trust's investment and capital replacement plan through a reduction of EBITDA compared to plan or increased debt compared to plan. This would also impact on the Financial risk rating for the Trust. Cost control, performance management systems fail to prevent avoidable cost increases and reduced financial efficiency. Delivery of the annual plan is adversely impacted due to delays in the completion of significant service developments. Opportunities to improve efficiency or patient care are delayed reducing profitability and ability to deliver plan agreed with the Board and Monitor. Trust slow to respond to reduced profitability, impacting on achievement of plan and future financial stability.	N	TW	Apr-11	Financial	5	5	25	Director of Finance and Performance	Apr-15	Framework for 3 year rolling Efficiency programme in place. Focus on high value cross cutting themes. Key areas for efficiency improvement identified through benchmarking assessments. Programme Boards, with Executive leadership, formed to manage key corporate improvement areas, e.g. theatre productivity, revisions to patient pathways. Assurance provided through extended gateway process, including tracking system. Routine reporting of planning and performance of efficiency programme through CPMT meetings and Finance & Investment Committee.	CIP stretch target of £30 million planned for 2014/15. Full plan submitted to March 2014 F&IC. Merging the resources of the Programme Office with the Service Improvement team to explore and develop a wider, more effective range of CIP schemes. Likely to benefit from the arrangements being made with CCGs Performance monitored at monthly meetings and recovery plans produced to confirm full achievement at year end. Savings performance will be against the stretch target	4	4	16	↔

Ranked position	Risk type	Risk No.	Risk Name	Source of Risk	Risk Description	Health & Safety Related?	Site	Date Added	Governance level	Consequences (current)	Likelihood (current)	Risk rating (current)	Executive Lead	Target Date for Completion	Controls in place	Additional Actions/Progress	Consequences (mitigated)	Likelihood (mitigated)	Risk rating (mitigated)	Movement
3	Performance	34	A&E performance targets	Board of Directors	The 2011/12 Operating Framework contained a number of new standards relating to A&E performance. These are now used as internal stretch targets and Monitor has reverted to compliance against the four-hour admission/discharge standard for A&E at 95%.	N	TW	Apr-11	Clinical/Operational	5	5	25	Interim Director of Operations	Apr-15	There has been financial support in terms of reablement funding which the Trust has been utilising. EKHUFT have been in discussion with Commissioners and Provider Partners with regards reablement schemes and support for 2014/15, with a view to building on the work undertaken during this winter, especially with regards additional external capacity. Analysis of Delayed Transfer of Care patients is sent daily to Community/Social Service and other Health care providers. EKHUFT have also worked with Social Services to ensure the accuracy of reportable DTOC's as well as the inclusion of a 'working total' to provide an internal early warning system for each acute site. Multi-agency teleconferences are held twice weekly, increasing to daily when under sustained pressure. There has been minimal impact of community schemes for admission avoidance.	Quarterly meetings are held with the Chief Executive, Chairman, Chief Operating Office and the Non-Executive Directors to review the performance of A&E. These meetings are used as a way of discussing the operational issues facing the departments and how to address these. There is an Urgent Care Integrated Care Board which is chaired by Commissioners. The increased pressure recognised throughout the year to date continues. Mitigations include, use of additional agency staff, the direct deployment of GP's in AE and weekend overtime working by senior clinical and managerial staff. There are associated work streams for readmissions, DTOC and the frail elderly pathways. Poor mental health provision - lack of psychiatric liaison service from 24.00 to 09.00 and lack of bed capacity for dementia patients; the Trust is seeking an alternative provider	4	4	16	↔
4	Finance	29	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Finance and Investment Committee	Movement from block to cost per case for non-elective work increases the risk associated with demand fluctuations, activity capture and competition. Proposed further changes to contract types that could change the balance of risk between commissioner and provider. The transfer of activity to Specialist Commissioning Contracts and Public Health Contracts increases the risk of challenge fro non-payment due to non-commissioned activity	N	TW	Apr-11	Financial	5	5	25	Director of Finance and Performance	Apr-15	Contract monitoring in place. Detailed activity plans to monitor variances. Data capture has been tested and checked for robustness. The contract for this year has negotiated out a number of issues that led to previous contracting disputes. The separation of SCG and CCG commissioners has been a problem and does increase the risk associated with the split issue should be less this financial year. The capped PbR contract will effectively encourage a reduction in activity is managed. The Trust is more exposed to a financial problem resulting from over performance of this contract	The contract allows for a more collaborative approach to contract management, plus a cap on fines of £4million. The capped PbR contract gives a potential "amnesty" on coding issues. No risk of new challenges over pricing and coding, however, any income above the CCGs threshold will not generate a payment. Fines will not exceed the £4million contract value	4	3	12	↔

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5	Clinical Quality	3	Patient safety, experience and clinical effectiveness compromised through inefficient clinical pathways and patient flow	Directorate risk registers	Unplanned use of extra beds with un-resourced staffing and patients outlying form their appropriate speciality, which may compromise patient safety and resulting delays	N	TW	Jun-10	Clinical/Operational	4	5	20	Chief Nurse and Director of Quality & Interim Director of Operations	Apr-15	Managed by General Managers and Senior Site Matrons in post at KCH, QEQM and WHH. Leadership & management programmes are underway to facilitate changes. Monitoring and assurance provided by daily bed meetings (0900hrs, 1600hrs and 1645hrs - UCLTC), weekly operational meetings, fortnightly NED's meetings to review capacity and flow data, monthly site lead meetings with UCLTC Top Team reviewing length of stay and net admission to discharge ratio (RR) and fortnightly performance improvement meetings chaired by CN&DoQ&O commenced. Updated weekly to ensure immediacy of the information required. Performance dashboard includes indicators of additional beds and outliers. Review of bed management system currently considering a move to an electronic system supporting real time reporting. The Emergency Care Improvement Programme is in place which covers LOS. This risk is linked to risk number 34 - A&E targets	Bed management review of current systems & group established to review national processes & benchmark current practice. Linked to reduction of additional beds/outliers through improved systems & bed management systems. Medical Director, Chief Nurse & bed holding Divisions reviewing, with consultants & matrons. EC-IST review of whole system, recommendations driving improvements with work programme to support better patient flows. Progress & successes to be measured e.g. Internal Waits Audit, defining Top 10 pathways of care for high risk specialities to improve efficiencies around capacity and reduce readmissions, extending Outpatient Clinic sessions from 3.5hrs to 4hrs, EDD and EDN accuracy and timeliness, qualitative analysis of UCLTC Morbidity & Mortality meetings, review of Discharge and Choice Policy and review of job plans to enable more timely ward rounds. Capacity profiling shows reduction in extra beds & improvements in outliers. Reablement schemes agreed with commissioners to improve flow outside the Trust.	4	3	12	↔
6	Service	52	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	CSSD. Division Risk Register	The delayed implementation of the PACS/RIS replacement system is affecting the ability of the Trust to report and book appointments using an electronic system. This could result in patients not receiving a timely diagnosis or treatment of their clinical condition. The increasing backlog of reports increases the risk	N	TW	Jul-13	Clinical/Operational	5	4	20	Interim Director of Operations	Dec-14	Dedicated implementation programme and risk register for the project with a daily meeting with suppliers and partners to resolve concerns and implementation delays. Project managed by a Kent and Medway Steering Group. Formal medical imaging project consortium framework agreement signed and in place with preferred supplier. Additional staff cover to type imaging reports but a backlog does exist.	Review of pathways for patients with known cancers to ensure all imaging and reports are available for every MDT. Go live with the GE system with workarounds in place, ensuring that there is a clear plan with timescales for the outstanding technical issues to be resolved. Upgrade to current system agreed for implementation in the new year. Agreement by GE Healthcare to compensate for the addition staff costs for the consortium	4	3	12	↔
7	Quality	59	Staff survey and staff engagement	Board Assurance Framework & survey results	The objective to improve the overall score in the staff survey is not likely to be met. The scores from the staff Friends and Family Test (FFT) showed a deterioration in performance from Q1 to Q2, in the section staff recommending the Trust as a place to work, following the national publication of the CQC inspection reports	N	TW	Sep-14	HR	4	5	20	Director of HR	Mar-17	The We Care programme has been established for two years and the next step is to commission the services of a partner to support the next steps in the programme. The "delivering our cultural change" was initiated in September 2014. It is anticipated that the programme will take between 18-24 months to complete, but a diagnostic phase is required in order to guide the specific work streams.	The We Care Steering Group will monitor delivery of the plan, through their monthly meetings, with regular reports to the Quality Board. Local issues and actions will be monitored by Division through the quarterly FFT surveys and executive performance reviews. Collaboration with our external partners to develop and agree overall programme progress "checkpoints", which will include feedback from front line staff and those involved in delivering the programme will take place. This will allow the identification of:- • emerging issues to help the Executive Team identify positive and negative drivers for staff engagement and motivation; • any of quick wins by which senior leadership can demonstrate listening and connection with front line staff; • any changes required to the programme in response to feedback. The success of this programme will be monitored by the Board through the production of a quarterly report, reporting against key milestones and outcomes, evaluating progress and making recommendations on changes as necessary.	4	3	12	New

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8	Clinical	54	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service	Directorate Risk Registers	Delays in the provision of sterile chemotherapy drugs resulting in patient safety, patient experience, staff morale and clinical trial activity risks	N	KCH	Apr-14	Clinical/Operational	4	5	20	Medical Director	Mar-15	The whole service has been closed temporarily whilst the underlying problems are rectified; this includes ordering chemotherapy agents from an external source. A full RCA is being carried out into the whole service and the gaps in service and stock control identified across the pathway. This will be presented to the RMGG once complete and the identified action monitored.	Patients kept informed of the changes to the service and redress for extended parking has been paid by the Trust. There is weekly meeting in place between cancer services and pharmacy. The additional stress being experienced by staff is being managed and further support offered. The Qualified Person (QP) for the service has recently resigned. There is provision in place for locum cover whilst a permanent replacement is identified. The phased re-opening of the service has been affected as a consequence	4	2	8	↔
9	Clinical Quality and Operations & Finance	30	Internal - Operational Performance Targets	Finance and Investment Committee	Trust is fined in year for failure to meet targets such as same sex accommodation, readmissions, delayed Ambulance transfers and non collection of appropriate data.	N	TW	Apr-11	Financial	5	4	20	Director of Finance and Performance & Interim Director of Operations	Apr-15	The unmitigated consequences are significant and the potential in year impact could exceed £5 million and over the 3 years, exceed £10 million. The single largest contract penalty that the Trust is exposed to is associated with readmissions. The financial range of penalty has been valued at £3-£9 million per annum.	The contract for 2014/15 is based on the Trust's plan, including its own risk evaluation for readmissions being £3 million. The capped PbR contract removes the exposure for the Trust of any greater fine	2	2	4	↔
10	Quality	4	Achieving quality standards/CQUINS	Board of Directors	The 2014/15 CQUIN programme remains at 2.5% of out turn equivalent to £9 million. The tolerances for some CQUINS are more stringent than in previous years with limited scope for partial payments	N	TW	Jul-09	Strategic	4	4	16	Chief Nurse and Director of Quality & Operations and Medical Director	Apr-15	The Trust's performance against quality standards generally compares well to other Trust's. The CQC QRP is reported to the Board monthly and supports this the quality objectives outlined within the Quality Strategy. There are clearly defined metrics aligned with the annual objectives. A programme manager manages the CQUIN and other quality programmes is in place. Performance is monitored by a group headed by the Chief Nurse and Director of Quality & Operations, supported by senior operational and Finance staff. The process is subject to ongoing monitoring with the lead commissioners through the CEG and reported monthly to the BoD	The 14/15 CQUIN programme includes 3 national and 4 local schemes. There is no agreed programme for Specialist Commissioning yet agreed. The greatest area of risk relates to the integrated care pathways, specifically the over 75/frailty which carries the greatest weighting at approx. £3million; there is a specific issue with the clinical lead for this pathway being the only clinical lead for the Trust. The financial risk assessments against targets is received monthly and the quality section to the CQ&PS board. This is also included in the BAF, which is reported quarterly to IAGC and RMGG. There is a separate and more detailed risk register to describe the specific risks to each pathway and the mitigation required; this will be monitored by the CQUIN and EQP/ERP groups. The development pathways for some pathways run over a two year period and will therefore link to the 2015/16 CQUIN programme.	3	3	9	↔