EAST KENT HOSPITALSUNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **28 NOVEMBER 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 19 November 2014 with the top 10 risks on the Corporate Risk Register (CRR). The top 10 risks were last received by the BoD at the October 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) in October. The full register was last presented to the Risk Management and Governance Group (RMGG) on 23 July 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 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	None	
Reduced		
Increased	Three	• Telephony system failure • Management of complaints and concerns • Non compliance with the admitted 18 week RTT
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	None	
Emerging	Eight	• 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 • Staffing issues in Finance • CQC Fundamental Standards - Legal Duty of Candour

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 November QAB and the emerging risks were reviewed at the Management Board on 19 November 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 19 November 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 30 October 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 meeting of the Quality Assurance Board on 22 October 2014. This report includes changes that occurred since the October meeting and the meetings of the Management Board (MB) in November 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) and the workplan for the committee revised to review the register in December 2014.

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 - Operational Performance Targets
10	4	Achieving quality standards/CQUINS

1.2. Significant changes to the Register since October 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 37 reported cases of C difficile within the new financial year at the time of this report. This equates to six 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 14 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 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. A revised diarrhoea risk assessment tool has been developed and is fully operational across the Trust.

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%; the standard was met in August at 95% but was non-compliant against the standard for September at 92.9%. There was a further failure to meet the standard in October at 92.8% and a failure to meet quarter 2 overall.

Challenges around activity and increased ambulance activity at the QEQM hospital have been significant in October. There have been consecutive days at QEQM where the number of patients in the department has been over 50 throughout the day, evening and early hours with over 20 patients in the department at 07.00. This has resulted in patients bedded in A&E on at least three occasions despite senior management and consultant support until midnight. These levels of activity are therefore having an impact on the department’s ability to deliver safe care which has been highlighted to the CCGs.

Further challenges experienced in October were as follows:

- Significant delays in accessing EMI, CHC and Fast Track bed capacity in the community.
- Continued early evening surges in activity with over 20 patients booking into ED in one hour.
- High volatility in SECAmb attendances with significant peaks of 87 at WHH, 50 at KCH and 87 at QEQMH per day.

- On the 16/17th October the ED Consultant, Anaesthetic Consultant and SECAmb commander were called to WHH to manage flow as the department was at risk.
- The GP in A&E service is now seeing a minimum of one and a maximum of two patients per hour at WHH and KCH.
- Daily monitoring of out of area ambulances has shown a continued 'creep' in ambulances coming from Medway and Maidstone area (ME) postcodes – average of five patients per day.
- Low staff morale due to high vacancies and increased workload.

The Action Plan is progressing with the majority of the actions rated as amber or green. There are no red actions currently.

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

1.3.1. **Risk 52 -** The clinical and patient safety risks associated with the delayed implementation of the PACS/RIS may reduce next month.

1.4. **Risks increased in October 2014 – Three**

1.4.1. **Risk 51 – Failure of Trust wide telephony system**
The supplier will not support the current system after 2017. Business Continuity Plans for each of the Trusts Telephone exchanges (PBX) are inadequate and unworkable for an extended period of time. Procurement of new telephony system is complete and configuration of the new system has started. The Trust wide phone number change has reduced the complexity of the implementation significantly. The project plan shows an 18 month roll out of phones; however this is being reviewed to see if the timescales can be shortened.

The unmitigated score is unchanged but the mitigation score increases from 4 to 10; this scoring has been re-assessed by the project lead.

1.4.2. **Risk 25 – Management of complaints and concerns in order to demonstrate learning**
The number and complexity of written complaints has increased significantly over the course of several months. Consequently, the Divisions have not consistently met the 85 per cent standard of responding within the timescale agreed with the client. There is a trend of more extensions to agreed dates for response being arranged with clients, common themes not improving month on month and some months have shown a rise in returning clients.

Further detail is contained within the supplementary report to the Board of Directors this month on complaints, which forms part of the Clinical Quality and Patient Safety Report. The unmitigated score increases from 6 to 10 and the mitigated score from 2 to 3.

1.4.3. **Risk 5 – Failure to meet and sustain 18 week referral to treatment time**
October performance shows the Trust was compliant with both the non-admitted and incomplete pathways standards at an aggregate level. Performance against these standards is deteriorating month on month as referrals in key specialties continue to over-perform the agreed contracted levels.

The Trust backlog position grew again during October ending the month at 1,474, an increase of 108 on the previous month. Orthopaedics and Dermatology grew by 64 and 62 patients respectively, and represent almost the totality of the growth. This is directly linked to the significant over-performance in demand seen in both of these specialties over the year so far. Whilst each of these specialties has managed to treat more breaches in month the rate at which patients are being added to the backlog is greater than the amount the Trust is able to treat resulting in a net growth. As agreed by the Trust Board, the Trust will continue to be non-compliant for the admitted standard. The non-admitted and incomplete standards are expected to be achieved, although due to the volume of referrals in pressurised specialties, this position may be challenged.

As per the plan endorsed by the Trust Board, the Trust is non-compliant with the admitted standard due to additional activity being undertaken to clear long waiters.

The unmitigated risk score increases from 12 to 15 and the mitigated score from 4 to 6.

1.5. **Risks removed from the Register in October 2014 – None**

1.6. **Risks added to the Register in October 2014 – None**

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. This risk has been mitigated by the identification of two Band 6 roles within the specialist division to support the Safeguarding team and the risk monitored via their divisional risk register ongoing.

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 has written 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. An NHS England led live exercise is planned shortly to test the Trust's resilience procedures for managing a patient carrying the Ebola Virus. The results of this test will inform the risk assessment.

1.7.7. There is an emerging risk on the Finance Risk Register as a consequence of the high number of staff vacancies and the loss of key skills with staff leaving the Trust. The risk is that this may impact on the achievement of current and future plans and financial stability. Gaps within key personnel are being identified and covered, in the short-term with temporary staff before permanent recruitment. This risk has yet to be discussed and approved at the F&IC. The pre-mitigation score is currently 15 and the post mitigation score is 10.

1.7.8. CQC fundamental standards, which replace the current 16 essential standards for quality and safety. Two standards come into force on 27 November 2014 for the acute sector; these are the duty of candour and the fit and proper persons requirements. The remainder come into force from April 2015. The duty of candour places a legal duty on the Trust to notify patients and relatives in writing when an incident resulting in moderate or severe harm or death occurs during an episode of care. Once the patient has been told in person about the notifiable patient safety incident, the organisation must provide the patient with a written note of the discussion, and copies of correspondence must be kept. The statutory duty of candour will be brought about through CQC registration regulations.

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:

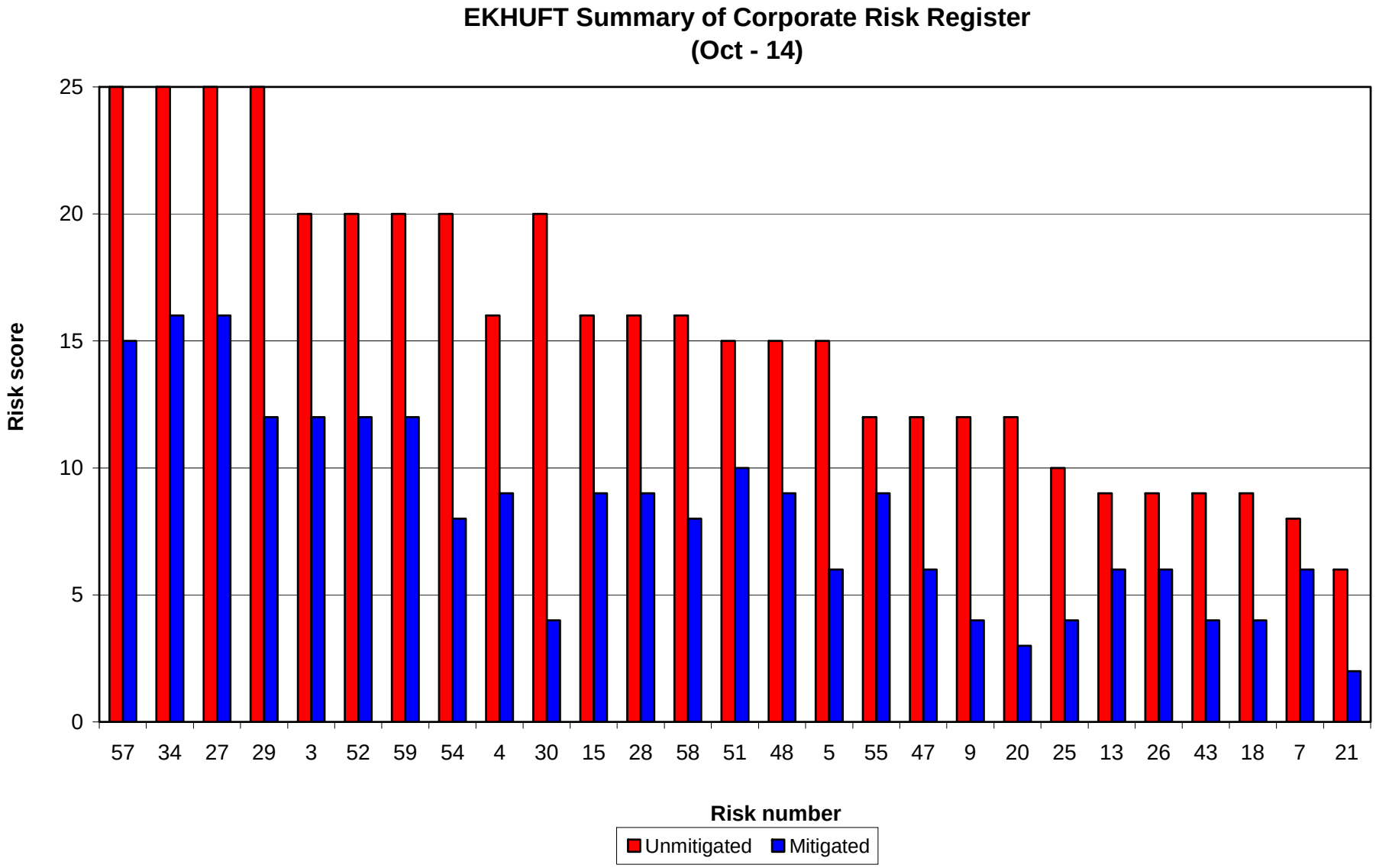
3.1. Note the report, discuss and determine actions as appropriate and approve the revised risk register.

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	Reputational risk to the Trust as a consequnce of the publication of the CQC inspection rpert	Nov-14	Julie Pearce
2	34	25	16	A&E performance targets	Nov-14	Giselle Broomes
3	27	25	16	Internal - Financial Efficiency Improvements and Control	Sep-14	Mark Austin
4	29	25	12	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Sep-14	Mark Austin
5	3	20	12	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient	Nov-14	Julie Pearce
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	Nov-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	Oct-14	Mary Tunbridge/Obafemi Shokoya
9	4	16	9	Achieving quality standards/CQUINS	Sep-14	Helen O'Keefe
10	30	20	4	Internal - Operational Performance Targets	Sep-14	Jeff Buggle
11	15	16	9	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Nov-14	Sue Roberts
12	28	16	9	External - Cost and Income Pressures including Technical Changes	Sep-14	Mark Austin
13	58	16	8	Effective diagnosis and management of sepsis	Sep-14	Michelle Webb
14	51	15	10	Business continuity and disaster recovery solutions for Trust wide telephony	Oct-14	Andy Barker
15	48	15	9	Patient experience concerns following transition of current Transport Service to a new national provider	Dec-13	Finbarr Murray
16	5	15	6	Failure to meet 18 weeks RTT	Nov-14	Marion Clayton
17	55	12	9	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Nov-14	Jane Ely
18	47	12	6	Winter planning and capacity management	Sep-14	Julie Pearce
19	9	12	4	Loss of clinical reputation due to unmitigated patient safety risks	Oct-14	Michelle Webb
20	20	12	3	Compliance with Information Governance Standards	Sep-14	Michael Doherty
21	25	10	4	Management of complaints and patient experience	Nov-14	Sally Smith
22	13	9	6	Age and Design of Trust constraint EKHUFT being top 10 in England	Jun-14	Finbarr Murray
23	26	9	6	Profile and effectiveness of the clinical audit function	Oct-14	Robin Ufton
24	43	9	4	Embedding Divisional Quality Governance	Nov-14	Helen Goodwin
25	18	9	4	Complexities of Managing the Market	Jun-14	Rachel Jones
26	7	8	6	Incomplete health records (risk re-named and re-scored August 2010)	Dec-13	Marc Farr
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

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 with Monitor and subject to a monthly review meeting. A series of diagnostic programmes have commenced; these include divisional governance and data quality. A Ward to Board governance review is also proceeding with a report due in December 2014.	A series of engagement events with staff have taken place, but more work of staff engagement is 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 the HLIP, supported by an Improvement Plan Delivery Board with staff involvement. A formal Improvement Director was appointed by Monitor and she has overseen the publication of the NHS Choices Action Plan on their website. A clinical lead to support the programme was appointed in November 2014.	5	4	20	↔
2	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, surge resilience funding, additional consultant weekend cover, recruitment to vacant middle grade and substantive consultant posts, increased psychiatric liaison serves and joint post for a critical care paramedic resource at the QEQM for 3 months	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	Finance	27	Internal - Financial Efficiency Improvements and Control	Finance and Investment Committee	Trust fails to meet its savings target for 2014/15, the £25.2 million and the 2016/17 £9.0 million targets and without action with Trust will miss its CIP target by more than £10 million. Working 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 Management Board 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. The focus of control is around ongoing project review and scrutiny from Trust committees and expert technical departments	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 NEDs 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 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. A preferred supplier has been identified and a culture change programme manager recruited. The programme of staff listening exercises will continue and a revised raising concerns policy approved.	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	↔

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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 QAB 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 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	↔