1. Summary

1.1. Explanation

This document provides the Board of Directors (the Board) with the top ten risks on the corporate risk register as at 16 April 2014. The full register was last presented to the Board at the January 2014 meeting, the top ten risks were reported at the meeting on 28 March 2014. The full Corporate Risk Register was received by the Risk Management and Governance Group (RMGG) on 29 January 2014 and the top 10 risks were reported on at the last meeting on 26 March 2014. This report includes changes that occurred since the March meeting. The financial risks were last discussed at the FIC on 28 January 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	27	Internal - Financial Efficiency Improvements and Control
2	34	A&E targets and emergency pathways
3	29	External - CCG Demand Management, Contract Negotiations and Financial Challenges
4	3	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient flow
5	52	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS
6	54	Temporary closure of the aseptic service
7	53	Trust response to the Reports into the provision of surgical services by the Royal College of Surgeons and the Health Education KSS
8	56	Interim centralisation of the management of high risk and emergency surgery
9	4	Ability to achieve quality standards/CQUINs
10	15	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates

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

1.2.1. **Risk 15 - Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates.** Eight MRSA bacteraemia cases were assigned to the Trust during the 2013/14 financial year. This performance is above that of the past two previous years and is now above the de minimis position of six cases that triggers scrutiny by Monitor; this is at the same level within Monitor's recently published Risk Assessment Framework. Four cases were judged to be unavoidable during Post Infection Review (PIR); one case was reported on the Medical Certificate of Cause of Death in Part 1 and has, therefore been reported externally via STEIS. Two cases were contaminants and the remaining two cases were considered to have been avoidable and a number of areas for potential improvement have been identified and are being addressed. These include more reliable measures for ensuring that MRSA screening results are passed on to primary care teams after patient discharge and routine consideration of MRSA status when selecting antibiotic therapy for ward patients. Four cases were typed as being the Lyon strain.

The Clostridium difficile cumulative total for the financial year 2013/14 was 49, 20 above trajectory. Most of the excess cases are in the UCL&TC division. A Root Cause Analysis for each case was undertaken; seven cases were classed as avoidable/non-compliant, 29 were considered unavoidable, but non-compliant with all policy requirements and the remaining 13 were unavoidable and fully compliant with all policy.

The performance in quarter 1 was above that seen in previous years' performance. The reason for the increase in cases is unknown but is likely to be the extreme workload pressures during the first quarter of 2013 and the high acuity of patients. During this period, an increase in broad spectrum antibiotic usage (Tazocin and Levofloxacin) was observed and preliminary data suggests that usage has begun to fall back to baseline. A comprehensive C. difficile recovery plan is in place and Public Health England reviewed the programme and was supportive of the initiatives in progress. A hydrogen peroxide vapour decontamination programme is in progress.

The Trust target for C. difficile for 2014/15 has recently been published; this is 47 cases, which is in line with previous targets. There have been three reported cases of C difficile within the new financial year at the time of this report. 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. The risk remains in the top 10.

1.2.2. **Risk 34 - A&E performance targets** – Following a discussion at RMGG in November 2013 it was agreed to increase the pre and post mitigation risk scores; this remains the second highest risk affecting the Trust during the winter period. This risk is also linked to risk 47 "lack of a whole systems response to winter pressures" and to risk 3 "patient safety risks associated with inefficient clinical pathways and patient flow".

The Trust met the four-hour standard in March 2014 with a performance of 95.2 per cent; there was a significant variance in performance during the month. The overall performance in quarter 4 met the four hour target, with 95.3 per cent of patients seen within four hours. There has been consistent activity at the Kent and Canterbury and William Harvey sites, with much more variability at the Queen Elizabeth the Queen Mother site which has seen higher volumes of Ambulance arrivals.

The Trust has overcome a number of challenges in order to attain the target in January and continue to achieve a good performance throughout the quarter. The main challenges have been surges/batching of ambulance attendances coupled with increasing acuity of patients, lack of community capacity and high volumes of evening attendances.

There also remains a variation in discharges throughout the week with a peak in activity on Friday and significantly lower numbers at the weekend. This is a feature across all three sites mainly due to insufficient non-acute capacity.

The following actions have been implemented to improve performance:

- Establishment of a commissioning - led DTOC Task and Finish Group by site;
- Utilisation of additional winter capacity through reablement bed schemes;

- Continued weekly Senior Integrated Board Rounds.

The Trust is also progressing implementation of the Winter Monies Funding schemes including:

- Continuing Health Care pilot at QEQMH
- Additional junior doctors to support to discharge/EDN completion at weekends;
- Additional consultant physician sessions at weekends ;
- Additional management support on site at weekends;
- Alternative transport arrangement;
- GP in A&E at QEQMH*;
- Additional consultant sessions in A&E
- Mental Health - 24 hour Psychiatric Liaison
- Crossroads support for patients with Dementia
- Community Geriatricians / Emergency Care Practitioners model*
- Implementation of the Hospital Integrated Discharge team at weekends at WHH
- Increased therapy input into community Hospitals to support discharges**
- Additional therapy input during evening and at weekends

** EKHUFT working with local health economy partners to progress these schemes*
*** Community based scheme.*

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

1.4. **Risks increased in March 2014 – One**

1.4.1. **Risk 29 – External financial risk – CCG demand management, contract negotiations and financial challenges** – following a review of the financial risk register by the Finance and Investment Committee, the unmitigated risk score was increased to 25; the post mitigation score however, remains unchanged. This change follows the outcome of various meetings with the CCGs who have indicated they will pursue significant reductions in the value of the 2014/15 contract. The ability of CCGs to deliver demand management is deemed to be similar to that of the old PCTs. New guidance suggests that Monitor will expect the Trust to support CCG demand management schemes by including then in the Trust plans. This reduces the Trust's ability to manage risk effectively and exposes the Trust to increased variances if the CCGs fail to deliver demand management schemes.

The unmitigated risk score is increased to 25 and the post mitigation score remains unchanged at 12.

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

1.6. **Risks added to the Register in March 2014 - Three**

1.6.1. **Risk 54 - Temporary closure of the aseptic service**. The Aseptic Unit (ASU) is a licensed manufacturing unit that manufactures and dispenses sterile chemotherapy and monoclonal antibodies to the Cathedral Day Unit, Brabourne Unit, CBC, and VDU on a daily basis. There were a number of delays to the provision of these drugs, which were highlighted in August 2013. During the improvement modelling a number of other issues were identified. These range from inadequate Standard Operating Procedures, concerns regarding staff competency, inadequate stock control and financial deficiencies. In order to address these issues and to provide a safe platform for the future, the service has been temporarily suspended. During

the forced shut down, the ASU will revert to the contingency plan of outsourcing all chemotherapy to Bath (ASU), for delivery of chemotherapy to all scheduled patients; no patient treatment will be cancelled. Despite the contingency of the Bath Unit, there have been further delays to the administration of chemotherapy to patients.

A detailed risk assessment has been undertaken by the Specialist Division, which identifies several overall themes for the risk. These include:

- Clinical risks
- Patient experience
- Effects on the workforce and
- The effects on clinical trials activity.

The unmitigated risk score is 20 and the post mitigation risk score is 8.

1.6.2. **Risk 55 – Inability to meet the 62 day screening standard consistently**. The current un-validated position for March 2014 shows compliance against all cancer targets apart from the Subsequent Drug standard. It is predicted that after validation is completed, this target will remain non-compliant. All other performance measures will be met. The 62 Day Screening standard was not met for either Quarter 3 or 4. Performance Improvement is being led by the Specialist Division working closely with the Surgical and Clinical Support Divisions. All tumour sites have been compliant against the 2-week wait target in March 2014. The 62 day treatment target has seen an improvement against target in March 2014. Close monitoring of this target is ongoing and being undertaken by all tumour sites. Improvements in escalation processes and patient tracking list (PTL) meetings have also been implemented this month. The Cancer Compliance team have been working closely with the Surgical and Clinical Support Division to review the internal diagnostic waiting times to improve the pathway. With the work already completed and further plans for improvement, Quarter 1 14/15 is predicted to be compliant against this target.

The unmitigated risk score is 12 and the post mitigation score is 9.

1.6.3. **Risk 56 - Centralisation of the management of all East Kent high risk and emergency general surgery at Kent and Canterbury Hospital.** This is an interim measure to ensure that high risk emergency and elective general surgery for all of East Kent can be delivered in the safest way possible. There is recognised serious clinical risk that will arise in high risk general surgery because of insufficient gastrointestinal surgeons being available to provide emergency cover, twenty four hours a day seven days a week. This has arisen because of the increasing sub-specialisation of surgery, the lack of availability of surgeons with skills that are essential to managing high risk and emergency surgery, and the difficulty recruiting both permanent and locum medical staff. If rotas continue to be maintained at two centres they would become staffed predominately by locum surgeons, which would have potential implications for patient safety, which the Trust cannot ignore. The Trust has taken steps to address these issues, but there remains a problem in recruiting sufficient appropriate surgical staff to maintain two emergency rotas. The first programme management meeting has taken place and work streams are being populated. There is greater evidence of staff engagement across all sites in order to review the direction of travel and the critical path. A weekly communication to all staff regarding progress is taking place.

This risk was presented at the March RMGG meeting by the surgical division; the unmitigated score is 16 and the post mitigation score is 12.

1.7. **Emerging Risks – Two**

1.7.1. 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 are expected in May 2014. It is possible that the Trust will not be compliant fully with the standards for the treatment 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 commences 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 will be discussed at the RMGG in April.

1.7.2. There has been a recent visit to the Kent and Canterbury Hospital site by Health Education Kent Surrey and Sussex (HEKSS) following concerns about patient safety raised by the trainees. The issues mainly affect the supervision of trainees within the Emergency Care Centre and medical cover out of hours. The Urgent Care and Long Term Conditions Division are taking the lead on developing an improvement programme and working closely with the trainees in order to more fully understand their specific patient safety concerns. Two senior consultants based at the KCH site are leading the improvement programme and a junior doctor representative is being sought from the site to participate in the Trust wide Trainee Patient Safety Group (TPSG) which reports into the Patient Safety Board. The aim of the TPSG is to explore and improve the safety of patients and help reduce frequently occurring medical errors experienced by doctors in training. The Trust has identified funding to send two trainees on the forthcoming national Patient Safety Congress in May 2014.

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 2013/14 and the internal systems currently in place to control and manage risk effectively.

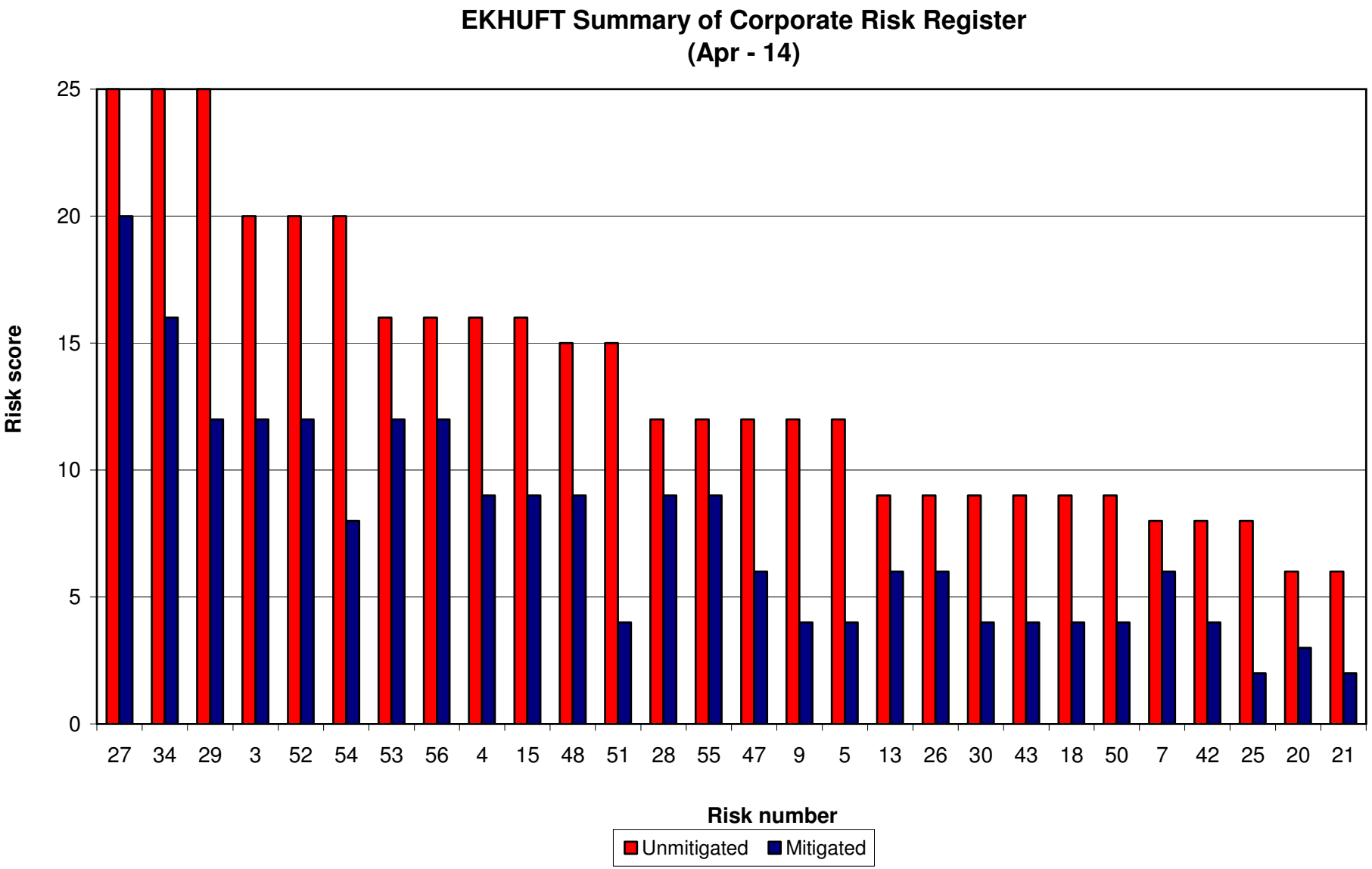
3. The Board of Directors are requested to:

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	27	25	20	Internal - Financial Efficiency Improvements and Control	Jan-14	Mark Austin
2	34	25	16	A&E performance targets	Mar-14	Giselle Broomes
3	29	25	12	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Jan-14	Mark Austin
4	3	20	12	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient flow	Mar-14	Julie Pearce
5	52	20	12	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	Mar-14	Marion Clayton
6	54	20	8	Temporary closure of the aseptic service	Apr-14	Jane Ely/Obafemi Shokoya
7	53	16	12	Trust response to the Reports and concerns into the provision of surgical and services by the Royal College of Surgeons and HEKSS	Mar-14	Noel Wilson/Marion Clayton
8	56	16	12	Trust response to the patient safety concerns raised by trainees and HEKSS at the KCH site	Apr-14	Jonathan Hawkins/Giselle Broomes
9	4	16	9	Achieving quality standards/CQUINS	Mar-14	Helen O'Keefe
10	15	16	9	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Mar-14	Sue Roberts
11	48	15	9	Transition of Current Transport Service to a new national provider	Dec-13	Fin Murray
12	51	15	4	Business continuity and disaster recovery solutions for Trust wide telephony	Mar-14	Anne Neale
13	28	12	9	External - Cost and Income Pressures including Technical Changes	Jan-14	Mark Austin
14	55	12	9	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Apr-14	Jane Ely
15	47	12	6	Winter planning and capacity management	Jan-14	Julie Pearce
16	9	12	4	Loss of clinical reputation due to unmitigated patient safety risks	Oct-13	Michelle Webb
17	5	12	4	Failure to meet 18 weeks RTT	Mar-14	Rachel Jones
18	13	9	6	Age and Design of Trust constraint EKHUFT being top 10 in England	Apr-12	Anne Neale
19	26	9	6	Profile and effectiveness of the clinical audit function	Jan-14	Robin Ufton
20	30	9	4	Internal - Operational Performance Targets	Oct-13	Julie Pearce
21	43	9	4	Embedding Divisional Quality Governance	Jan-14	Helen Goodwin
22	18	9	4	Complexities of Managing the Market	Apr-13	Liz Shutler
23	50	9	4	Spencer Wing (Healthex Group)	Jan-14	Jeff Buggle
24	7	8	6	Incomplete health records (risk re-named and re-scored August 2010)	Dec-13	Marc Farr
25	42	8	4	Adult Safeguarding	Dec-13	Helen Goodwin
26	25	8	2	Management of complaints and patient experience	Mar-14	Sally Smith
27	20	6	3	Compliance with Information Governance Standards	Mar-14	Michael Doherty
28	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