EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**21 MAY 2015**
SUBJECT:	**CORPORATE RISK REGISTER – TOP 10**
REPORT FROM:	**INTERIM 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 11 May 2015, with the top 10 risks on the Corporate Risk Register (CRR). This report includes changes that occurred since the last Quality Assurance Board (QAB) in May 2015. The top 10 risks were received by the Board of Directors at the April 2015 meeting; the full register was reviewed by the Board in January 2015. The top 10 risks were last reviewed by the Integrated Audit and Governance Committee on 14 April 2015 and the full register was reviewed on 19 January 2015. The emerging risks were last reviewed by the Management Board on 20 May 2015 and decisions made regarding the addition of three new risks.

SUMMARY

There are four risks with an unmitigated risk score of 25 and six with a score of 20. The top 10 include:

- the quality, safety, financial and reputational consequences associated with the CQCs' published report into the Trust the internal financial efficiency programme;
- the deterioration in A&E performance standard and the potential risk to patients waiting longer than four hours;
- the internal financial efficiency and control;
- 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 and delayed transfers of care, 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;
- Board stability and potential loss of organisational memory with significant changes to the BoD;
- local and national difficulties in staffing and recruitment;
- sustained closure of the aseptic service;
- Internal operational performance targets.

The risk associated with the findings of the CQC report is the number one risk affecting the organisation currently.

The emerging and new risks were discussed at the Management Board and Quality Assurance Board (QAB) in May; these are further explored in the attached paper. The decision taken at that time was not to add the emerging risk relating or the Ultra Clean Vertical Laminar Flow units to the corporate risk register at the moment as this was being overseen by the Surgical Division/Strategic Development. This will however be subject to review in order that any significant changes to mitigation can be identified.

New	Three	• Trust wide compliance with mandatory training compromised by IT issues and interface with ESR • Board stability and potential loss of organisational memory with significant changes to the BoD • Implementation of the Kent Pathology Partnership and on-going sustainability
Reduced	One	• Clinical and patient safety risk associated with the implementation of the PACS/RIS
Increased	None	
Substantially changed	One	• HCAI – Clostridium difficile infections (CDI). The trajectory for 2015/16 has been identified and one case to date reported. There is a slight reduction this year to 45 cases. The reporting rate per 100,000 beds days is now slightly above the mean nationally
Removed	One	• Staffing shortfalls and substantive vacancies within the finance team. The new Director of Finance starts at the beginning of May 2015
Emerging	Four	• Staffing difficulties within the Speech and Language Therapy (SaLT) service • CQC Fundamental Standards - Legal Duty of Candour and fining for breaches and the potential for NHSLA • Potential patient safety issues associated with the treatment of cholesteatoma • Out of hours' cover for interventional radiology

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:
An updated position will be presented to the QAB in June 2015.

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 an update of progress, as at 11 May 2015, with the top 10 risks on the Corporate Risk Register (CRR). This report includes changes that occurred since the last Quality Assurance Board (QAB) in May 2015. The top 10 risks were received by the Board of Directors at the April 2015 meeting; the full register was reviewed by the Board in January 2015. The top 10 risks were last reviewed by the Integrated Audit and Governance Committee on 14 April 2015 and the full register was reviewed on 19 January 2015. The emerging risks were last reviewed by the Management Board on 20 May 2015. A number of decisions were made at the QAB in May regarding additional risks affecting the organisation; these are outlined in the new risks section.

The Corporate Risk Register has been reformatted within Datix in order to meet the recommendation made in the review of governance recently completed; this should fulfil the recommendation to place the risk register in a database. The structure of the output from the database is still being formatted in order to provide the necessary detail for the various committees receiving the register on a monthly basis. Progress has been made to use a database for the divisional risk registers, with that from Urgent Care and Long-Term Conditions already completed.

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	Quality, safety, financial & reputational consequences associated with the CQC's published report
2	34	A&E performance 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	59	Poor staff survey results and evidence of staff engagement
7	63	Board stability and potential loss of organisational memory with significant changes to the BoD
8	60	Difficulty in recruitment of staff against vacancies and national shortages in some hard to recruit posts
9	54	Temporary closure of the aseptic service due to non-compliance with service standards
10	30	Internal - Operational Performance Targets

1.2. **Significant changes to the Register since April 2014 – One**

1.2.1. **Risk 15 - Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates.** One case of MRSA bacteraemia was assigned to the Trust in 2014/15. The target for 2015/16 remains at zero avoidable cases.

The recent performance against the Clostridium difficile trajectory showed a 50 per cent reduction in the number of cases confirmed over the last two quarters of 2014/15. Public Health England confirmed the Trust met the trajectory of 47 cases for 2014/15, after considering the case acquired by a patient treated by the Hospital at Home Service should not be attributed to the Trust. The Clostridium difficile trajectory for the new financial year is 45 cases. The mitigating actions outlined below appear to be reducing the risk. The C diff rate per 100,000 bed days is, for the first time above the national rate; this position will need to be reviewed and monitored. The rate is 14.8 per 100,000 bed days.

A sustained improvement plan is in place including the implementation of Hydrogen Peroxide vapour system (HPV) for high level disinfection of clinical areas Trust wide as appropriate. A revised diarrhoea risk assessment tool has been developed and is fully operational across the Trust. 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. Compliance against the HOUDINI protocol forms a component of the Trust's submitted Patient Safety Programme for the next three years.

The target of 45 cases for this financial year is a risk but there is no intention to reduce the risk scores. This will however be reviewed against performance.

1.3. **Risks decreased in April 2015 – One**

1.3.1. **Risk 52 - Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS.** The implementation challenges have not resulted in an increase of patient safety incidents reported. The system effectiveness and efficiencies are monitored by the Clinical Support Division and by the Imaging Department. The unmitigated risk reduces from 15 to 10 and the mitigated risk form 10 to 8.

1.4. **Risks increased in April 2015 – None**

1.5. **Risks removed from the Register in April 2015 – One**

1.5.1. **Risk 62 - Staffing shortfalls and substantive vacancies within the finance team.** The new Director of Finance and Performance commences the first week in May 2015. Interim cover arrangements into the other senior finance positions are in place.

1.6. **Risks added to the Register in April 2015 – Three**

1.6.1. **Risk 63 – Board stability and potential loss of organisational memory with significant changes to the BoD.** There were a number of changes to the Board at Executive and Non-executive level that occurred towards the end of the last financial year. A number of new substantive appointments have been made e.g. Director of Human Resources, Chief Operating Officer and Director of Finance and Performance; the Trust has an interim Chief Executive in post. The Chief Nurse and Director of Quality leaves the Trust at the end of this month and the Deputy Chief Nurse and Deputy Director of Quality will assume the interim role.

There are changes to the BoD at the NED level and the Chairman also leaves at the end of this month. There are other positions at the NED level which will come to the end of tenure over the next six months.

Corporate memory will be supported by the tier of staff just below board level; however, there will inevitably be a period of instability as the Board which may affect performance.

The unmitigated risk score if 20 and the mitigated score 10; this places the risk in the top 10 affecting the Trust.

1.6.2. **Risk 64 - Trust wide compliance with mandatory training compromised by IT issues and interface with ESR.** Staff compliance with mandatory training is variable across the Trust and that reported via Qlikview directly from individual electronic staff records (ESR) does not correlate with staff feeding back to their managers on compliance. Staff also report difficulties both with accessing the relevant training through the National Learning Management System (NLMS) and consistently saving their completed assessments into their electronic staff record. The ability of staff to access the NLMS using Smartcards has been affected by the Trust wide changes to the web browser and the newer desktop PCs. PCs that do not have this functionality are marked, but all those in the libraries and post graduate centres are compatible.

Learning and Development have ensured that eLearning can now be accessed with a user name and password, therefore obviating the need for Smartcard access. The Information Team are developing an improved system, which should be in place by June 2015. This solution is by an enclosed server-based environment for all mandatory training outside the NLMS. This will contain the same course material but will be hosted internally by the Trust. The interface between this system and ESR will improve without the link to the NLMS.

There are additional challenges for Trust wide infection prevention and control training as the current Trust training programmes are no longer available on the NLMS following a recent upgrade to the national system. The Trust is developing

specific training materials with an outside agency, which will be available for staff using the enclosed training environment being developed. The cost of development is around £11K. This delay will affect the ability of staff to complete mandatory training in this area.

The unmitigated score is 15 and the mitigated score 9.

1.6.3. **Risk 65 - Implementation of the Kent Pathology Partnership and on-going sustainability.** There are a number of key areas of risk relating to the staff employed within the partnership; their TUPE arrangements and vacancies, the management of risk and the governance arrangements between MTW and East Kent and the new accreditation system now in operation nationally (ISO 15189:2012 standards).

There is a formal Board with representation from both MTW and East Kent; the new CEO started with the Partnership on 01/04/2015. The governance arrangements are currently being formulated with more visibility for staff who have been previously employed by both acute Trusts. The Microbiology transfer of staff under TUPE planned for April has been deferred until July 2015 in order to allow for further consultation with staff and Trade Union representation. Quality and clinical governance arrangements are also being reviewed to provide greater transparency of process and to ensure that RCA, SI, AAR complaints and claims are all managed appropriately and in the timeframes specified.

The unmitigated score is 16 and the post-mitigation score 6.

1.7. **Emerging risks**

1.7.1. Speech and Language Therapy (SaLT) services are a risk due to low staffing levels. The number of additional beds open has further increased demand for this service. SaLT services at the QEQM and K&CH were staffed by Kent Community Health Trust (KCHT) via an SLA until April 2014 when the staff became Trust employees under Transfer of Undertaking (Protection of Employment) arrangements (TUPE). Several members of staff had resigned prior to the TUPE and further staff have resigned since the change. SaLT services at WHH have always been EKHUFT employees and provide both in-patient and out-patient services. The service at QEQM and K&CH covers in-patients only and SaLT are not attracted generally to these posts as the diversity is limited. Consequently the recruitment to vacant band 6 and 7 roles has proved very difficult. Band 5 posts have been recruited to, but new graduates do not have the necessary competencies to manage the high risk patients with dysphagia without supervision. The band 8a service lead is part time rather than the recommended full time post which would offer more leadership across the sites.

Actions to be taken in the short term are as follows:

- Recruitment into SaLT vacancies continues
- Discussions with KCHT are taking place with a proposal to them taking over community and outpatient activity in the Ashford area.

Actions to be taken in the long term are as follows:

- Consideration of service transfer to KCHT as a whole as they have the flexibility and diversity of specialties/service areas to attract and retain staff.
- The Trust will then need to develop an SLA with KCHT for the in-patient service. A second option is to tender the service to another provider.

The highest priority in terms of patient safety concerns dysphagia management. It was agreed to add this to the corporate risk register.

1.7.2. CQC fundamental standards, which replace the current 16 essential standards for quality and safety. Two standards came into force on 27 November 2014 for the acute sector; these are the duty of candour and the fit and proper person's requirements. The remainder came into force on 01 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. There is a potential for any NHS organisation to be fine for any confirmed breach of this regulation equivalent to £2,500 per breach.

There are further changed mooted by the NHS Litigation Authority (NHSLA) whereby an NHS Trust has breached the statutory duty of candour about a patient safety incident which results in a claim, the NHS LA could have the discretion to reduce or remove that Trust's indemnity cover for that claim. This proposal could result in individual trusts having the liability for the component of a claim that the NHSLA fail to cover. The current position of the NHSLA regarding this matter has not yet been confirmed and the risk is difficult to evaluate currently.

1.7.3. The surgical division highlighted an emerging risk at the Management Board on 18 March 2015. Eight patients to date have represented to the Trust after having undergone Day case procedures for the treatment of cholesteatoma under the care of the same consultant surgeon. These patients now require very complex surgery with an increased risk of hearing loss. This consultant is now retired from the Trust, but is still practising in a private capacity. In order to understand more clearly the scope of the problem, a review has commenced of the past activity under this consultant. Until this audit is completed it is not possible to ascertain if the number of patients affected is higher than the eight currently identified.

1.7.4. Interventional radiology cover for out of hours. There is an on-going difficulty in recruiting to the vacancies within the interventional radiology service, which is affecting the out of hours/emergency cover. This has become more difficult and staff are currently working on a good will basis. Recruitment into the vacant posts is planned by September 2015. Additional equipment for the treatment of obstetric haemorrhage has been approved and this requires specialist clinical knowledge and training to use this safely in and out of hours.

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 2015/16 and the internal systems currently in place to control and manage risk effectively.

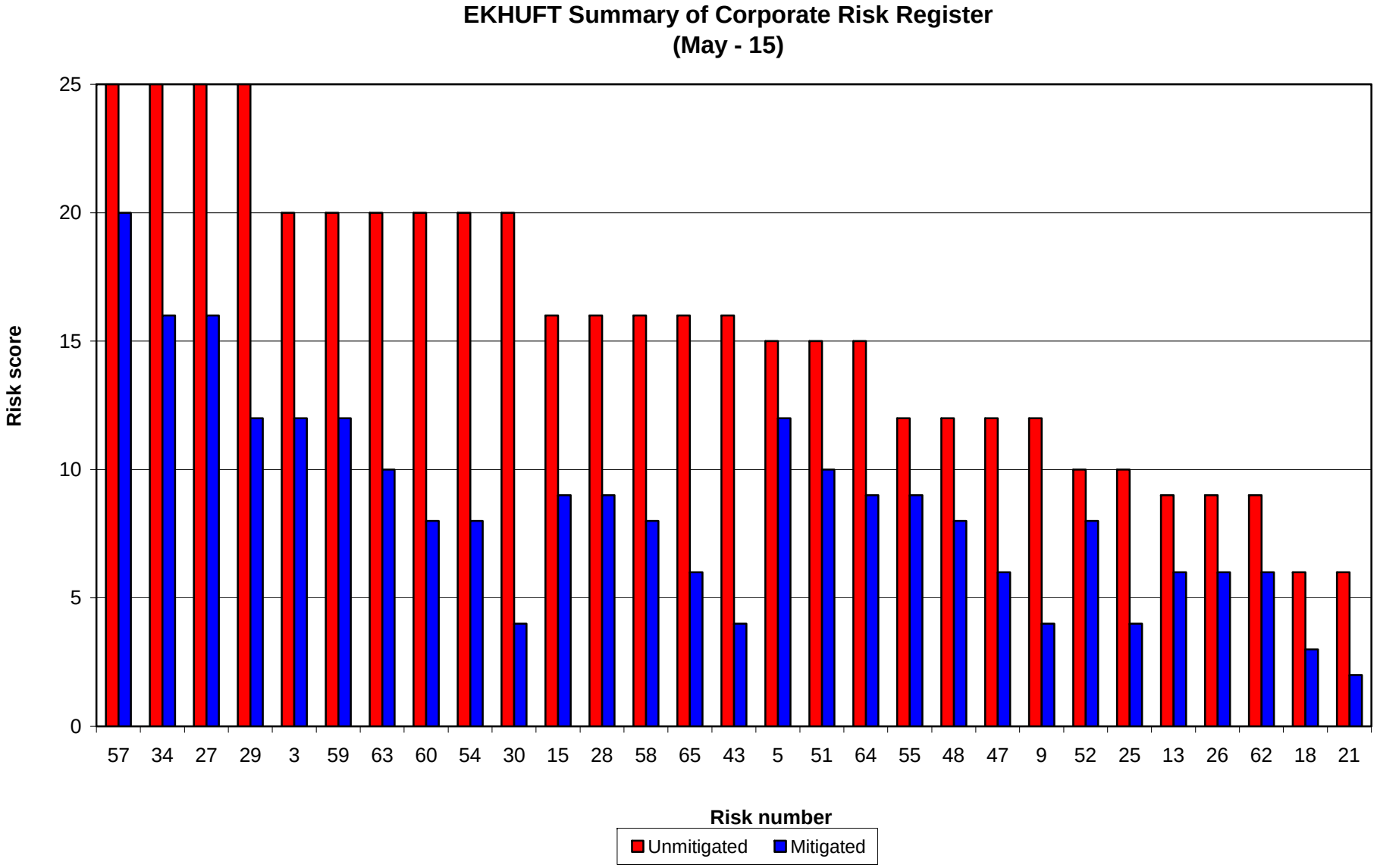
3. The Board are requested to:

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

4. Pre and Post Mitigation Scores

Current order	Risk number	Unmitigated	Mitigated	Description	Last Reviewed	Review Contact
1	57	25	20	Quality, safety, financial & reputational consequences associated with the CQCs' published report	Jan-15	Chris Bown
2	34	25	16	A&E performance and emergency pathways	Dec-14	Giselle Broomes
3	27	25	16	Internal - Financial Efficiency Improvements and Control	Feb-15	David Bains
4	29	25	12	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Feb-15	David Bains
5	3	20	12	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient flow	Nov-14	Jane Ely
6	59	20	12	Poor staff survey results and evidence of staff engagement	Nov-14	Sandra Le Blanc
7	63	20	10	Board stability and potential loss of organisational memory with significant changes to the BoD	Apr-15	Chris Bown
8	60	20	8	Difficulty in recruitment of staff against vacancies and national shortages in some hard to recruit posts	Dec-14	Sandra Le Blanc
9	54	20	8	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service	Mar-15	Mary Tunbridge/Jo Ringer
10	30	20	4	Internal - Operational Performance Targets	Feb-15	David Bains
11	15	16	9	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Feb-15	Sue Roberts
12	28	16	9	External - Cost and Income Pressures including Technical Changes	Feb-15	David Bains
13	58	16	8	Effective diagnosis and management of sepsis	Jan-15	Michelle Webb
14	65	16	6	Implementation of the Kent Pathology Partnership and on-going sustainability	Apr-15	Mary Tunbridge/Jane Ely
15	43	16	4	Embedding Divisional Quality Governance	Feb-15	Helen Goodwin
16	5	15	12	Failure to meet 18 weeks RTT	Dec-14	Marion Clayton
17	51	15	10	Business continuity and disaster recovery solutions for Trust wide telephony	Oct-14	Andy Barker
18	64	15	9	Trust wide compliance with mandatory training compromised by IT issues and interface with ESR	Apr-15	Sandra Le Blanc
19	55	12	9	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Dec-15	Jane Ely
20	48	12	8	Transport Service to a new national provider - possible DTOC during transition phase	Jan-15	Finbarr Murray
21	47	12	6	Winter planning and capacity management	Mar-15	Jane Ely
22	9	12	4	Loss of clinical reputation due to unmitigated patient safety risks	Oct-14	Michelle Webb
23	52	10	8	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	Dec-14	Mary Tunbridge
24	25	10	4	Management of complaints and patient experience	Nov-14	Sally Smith
25	13	9	6	Age and Design of Trust constraint EKHUFT being top 10 in England	Jan-15	Finbarr Murray
26	26	9	6	Profile and effectiveness of the clinical audit function	Mar-15	Robin Ufton
27	62	9	6	Health and Safety compliance	Mar-15	Finbarr Murray
28	18	6	3	Complexities of Managing the Market	Jan-15	Rachel Jones
29	21	6	2	Blood transfusion process - vulnerable to human error	Feb-15	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	Risk Description	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	The quality, safety, financial and reputational consequences associated with the CQCs' published report into the Trust	5	5	25	Interim 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 has taken place and a report issued which highlights over 50 actions to be taken.	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 alongside a dedicated Programme Manager. A cultural change programme is being developed and embedded. This programme is subject to constant monitoring and specific risks identified as part of the on-going monitoring. The date for re-inspection is 13 July 2015 and this too subject to a separate programme, with clear workstreams identified.	5	4	20	↔
2	Performance	34	A&E performance standards	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%.	5	5	25	Director of Operations	Jun-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. The impact of the Perfect Week required evaluation.	4	4	16	↔

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3	Finance	27	Internal - Financial Efficiency Improvements and Control	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.	5	5	25	Director of Finance and Performance	Apr-16	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.	Full plan for 2015/16 to be submitted to March 2015 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. The focus of control is around ongoing project review and scrutiny from Trust committees and expert technical departments. New Project Management system introduced.	4	4	16	↔
4	Finance	29	External - CCG Demand Management, Contract Negotiations and Financial Challenges	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 for non-payment due to non-commissioned activity	5	5	25	Director of Finance and Performance & Director of Operations	Apr-16	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. Increase in contract value should occur in 2015/16.	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. The proper management of the contract in 2015/16 should provide the financial headroom to allow for service change to be completed.	4	3	12	↔

Top 10 corporate risks

Ranked position	Risk type	Risk No.	Risk Name	Risk Description	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
5	Operational	3	Patient safety, experience and clinical effectiveness compromised through inefficient clinical pathways, patient flow & delayed transfers of care	Unplanned use of extra beds with un-resourced staffing and patients outlying form their appropriate speciality, which may compromise patient safety and resulting delays	4	5	20	Chief Nurse and Director of Quality & Director of Operations	Apr-16	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	↔

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6	Quality	59	Staff survey and staff engagement	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	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	↔
7	Strategic	63	Board stability and potential loss of organisational memory with significant changes to the BoD	There are a number of significant changes to the Board of Directors at an executive and non-executive level within the next 1-6 months. There is a potential loss of organisational memory and a number of key positions are interim positions	4	5	20	Interim Chief Executive	Oct-15	Interim positions at CEO and Chief Nurse and Director of Quality have been identified and are in place. Recruitment into the COO and Director of Finance roles are in place and substantive. There is a recruitment process in place for the soon to be vacant position of Chair. NEDs reaching the end of their tenure will be replaced.	There is stability across the staff in Deputy director posts across key corporate and clinical areas. Monitor will continue to review performance as part of the programme of Special Measures.	2	5	10	New

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8	Clinical and operational	60	Difficulty in recruitment of staff against vacancies and national shortages in some hard to recruit posts	There are a number of vacancies within the Trust in nursing, medical and some allied health professionals and, due to national shortages in some of these areas, recruitment has proved problematic because of the competing demands of other organisations. NICE has published guidance on nurse staffing levels in ward areas and plans to publish for A&E	4	5	20	Director of HR	Apr-16	The Trust is finalising the six-monthly review into nurse staffing and acuity; the results of which will be presented at the BoD in January 2015. This includes a review of specialist areas as well as general ward based. The vacancy rate for each professional group is being monitored as part of the CQC Improvement Plan and there are targets agreed for each profession and for key specialty areas e.g. A&E, paediatrics and non-obstetric ultrasound. This will be reported at the monthly Monitor performance review meeting. The Trust is 85% through the £2.9 million investment into staffing, which was approved at the Board in November 2013.	The HR director has reviewed the recruitment pathway and there is a close working relationship with HEKSS and the local Universities to develop innovative approaches to training in some areas to release registered staff from some activities. Board paper on ward/specialist area staffing to BoD in Jan-15	4	2	8	↔
9	Clinical	54	On-going issues with MHRA compliance resulting in a sustained period a closure of the aseptic service	Inability to produce sterile chemotherapy drugs internally resulting in patient safety, patient experience, staff morale and clinical trial activity risks	4	5	20	Director of Pharmacy	Aug-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. An updated position was presented to IAGC in April 2015; there is likely to be a change to the current MHRA licensing to limit activity to Schedule 10 activity. The regional aseptic lead is assisting the Trust to ensure long term stability and safety of the service.	The phased re-opening of the service has been affected as a consequence of further staffing difficulties; the vacancies are now being recruited. There are plans to re-open and manufacture in June 2015 and a detailed plan is with NHSE. Financial risks are still evident with issues of stock control under a more robust governance process.	4	2	8	↔

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10	Quality and Operations	30	Internal - Operational Performance Targets	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. The readmissions fine is financially the most significant.	5	4	20	Director of Operations & Chief Nurse & Director of Quality	Apr-16	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. Some dispute with CCGs over the measurement of readmission penalty; this ranges from £2.5 to £6 million	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. Increased focus on readmissions monitored through the new project management programme	2	2	4	↔