Top 10 corporate risks

Ranked position	Risk type	Risk No.	Risk Name	Source of Risk	Risk Description	Health & Safety Related?	Site	Date Added	Governance level	Consequences (current)	Likelihood (current)	Risk rating (current)	Executive Lead	Target Date for Completion	Controls in place	Additional Actions/Progress	Consequences (mitigated)	Likelihood (mitigated)	Risk rating (mitigated)	Movement
1	Finance	27	Internal - Financial Efficiency Improvements and Control	Finance and Investment Committee	Trust fails to meet its savings target for 2014/15. 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 CPMT meetings and Finance & Investment Committee.	CIP stretch target of £30 million planned for 2014/15. Full planned to be submitted to March 2014 F&IC. Performance monitored at monthly meetings and recovery plans produced to confirm full achievement at year end. Savings performance will be against the stretch target	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	Chief Nurse and Director of Quality & 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 2013/14, 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 and a SAU implementation planned this financial year.	Quarterly meetings are held with the Chief Executive, Chairman, Chief Operating Office and the Non-Executive Directors to review the performance of A&E. These meetings are used as a way of discussing the operational issues facing the departments and how to address these. There is an Urgent Care Integrated Care Board which is chaired by Commissioners. The increased pressure recognised throughout the year to date continues. Mitigations include, use of additional agency staff, the direct deployment of GP's in AE and weekend overtime working by senior clinical and managerial staff. There are associated work streams for readmissions, DTOC and the frail elderly pathways. Poor mental health provision - lack of psychiatric liaison service from 24.00 to 09.00 and lack of bed capacity for dementia patients; the Trust is seeking an alternative provider	4	4	16	↔

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3	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. CCG challenges to income reach a level that adversely affects the achievement of income targets. 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.	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. Details shared in 6 month notice letter and adoption of CCG contract as basis of Trust plan should reduce type and number of challenges raised by CCGs/GPs. Continuous monitoring of referrals to identify changes in referral trend. Work with CCG to ensure managed service change. Discussion with GP consortia to ensure that changes in patterns of service provision are managed through a collaborative process within manageable time scales.	Discussion with CCGs to ensure that changes in patterns of service provision are managed through a collaborative process within manageable time scales. The transfer of MTW Acute Services to Pembury are likely to increase acute activity for EKHUFT.	4	3	12	↔
4	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 & Operations	Apr-15	Managed by General Managers and Senior Site Matrons in post at KCH, QEQM and WHH. Leadership & management programmes are underway to facilitate changes. Monitoring and assurance provided by daily bed meetings (0900hrs, 1600hrs and 1645hrs - UCLTC), weekly operational meetings, fortnightly NED's meetings to review capacity and flow data, monthly site lead meetings with UCLTC Top Team reviewing length of stay and net admission to discharge ratio (RR) and fortnightly performance improvement meetings chaired by CN&DoQ&O commenced. Updated weekly to ensure immediacy of the information required. Performance dashboard includes indicators of additional beds and outliers. Review of bed management system currently considering a move to an electronic system supporting real time reporting. The Emergency Care Improvement Programme is in place which covers LOS. This risk is linked to risk number 34 - A&E targets	Bed management review of current systems & group established to review national processes & benchmark current practice. Linked to reduction of additional beds/outliers through improved systems & bed management systems. Medical Director, Chief Nurse & bed holding Divisions reviewing, with consultants & matrons. EC-IST review of whole system, recommendations driving improvements with work programme to support better patient flows. Progress & successes to be measured e.g. Internal Waits Audit, defining Top 10 pathways of care for high risk specialities to improve efficiencies around capacity and reduce readmissions, extending Outpatient Clinic sessions from 3.5hrs to 4hrs, EDD and EDN accuracy and timeliness, qualitative analysis of UCLTC Morbidity & Mortality meetings, review of Discharge and Choice Policy and review of job plans to enable more timely ward rounds. Capacity profiling shows reduction in extra beds & improvements in outliers. Reablement schemes agreed with commissioners to improve flow outside the Trust.	4	3	12	↔
5	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	Chief Nurse and Director of Quality & Operations	Aug-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	↔

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6	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	Sep-14	The whole service has been closed temporarily whilst the underlying problems are rectified; this includes ordering chemotherapy agents from an external source. A full RCA is being carried out into the whole service and the gaps in service and stock control identified across the pathway. This will be presented to the RMGG once complete and the identified action monitored.	Patients kept informed of the changes to the service and redress for extended parking has been paid by the Trust. There is weekly meeting in place between cancer services and pharmacy. The additional stress being experienced by staff is being managed and further support offered. The Qualified Person (QP) for the service has recently resigned. There is provision in place for locum cover whilst a permanent replacement is identified. The phased re-opening of the service has been affected as a consequence	4	2	8	↔
7	Service	53	Trust response to the Reports into the provision of surgical services by the Royal College of Surgeons and HEKSS	Surgical Division	Removal of trainees at any of the three main trust sites would compromise the viability of services	N	WHH	Jul-13	Clinical/Operational	4	4	16	Divisional leadership team for the Surgical Division	Jan-15	Project manager recruited to oversee delivery of the RCS action plan. External surgeon support secured for one day per month. Team development expertise secured to support WHH site initially then whole team. Finance in place to secure additional capacity and project support.	New models of out of hours surgery agreed; to commence August 13 at QEQM and October 13 at WHH. Deanery action plan led by Director of Medical Education and supported by the Surgical Services Division. Immediate changes made to trainee support and engagement. More recent reports from trainees indicates a better experience. The most significant risk remains the removal of junior doctors from WHH - whilst this has been mitigated, the risk remains high. The follow up visit by the Deanery took place in September 2013; the report confirms that trainees will remain at the WHH.	4	3	12	↔
8	Clinical	56	Interim centralisation of the management of all East Kent high risk and emergency general surgery at Kent and Canterbury Hospital	Directorate Risk Registers	There are a number of unfilled sessions on the emergency rota for general surgery. 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.	N	TW	Apr-14	Clinical/Operational	4	4	16	Medical Director	Sep-14	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	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 and the surgical consultant body are meeting with the Executive leads to resolve the key issues. Workstream leads have been identified and the various options being assessed.	4	3	12	↔
9	Quality	4	Achieving quality standards/CQUINS	Board of Directors	The 2014/15 CQUIN programme remains at 2.5% of out turn equivalent to £10.4 million. The Trust must meet a series of gateways before the CQUIN performance targets can be reached. The tolerances for some CQUINS are more stringent than in previous years with limited scope for partial payments	N	TW	Jul-09	Strategic	4	4	16	Chief Nurse and Director of Quality & Operations and Medical Director	Apr-15	The Trust's performance against quality standards generally compares well to other Trust's. The CQC QRP is reported to the Board monthly and supports this the quality objectives outlined within the Quality Strategy. There are clearly defined metrics aligned with the annual objectives. A business case for a CQUIN programme manager has been approved and additional staffing resources identified to support each of the nine targets. 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 12/13 CQUIN programme includes 4 national, 3 cluster, 1 regional and 1 local scheme. 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 groups. The incorporation of a gateway this year requires additional performance criteria to be met before accessing the specific CQUIN pathways. These include compliance with - national data collection requirements, national access and quality standards, workforce planning indicators and full compliance with CQC registration. Plans underway for development of 2014/15 CQUIN programme	3	3	9	↔

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10	Quality	15	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Infection Control Team	Ability to maintain continuous improvement in the reduction of HCAIs in the presence of existing low rates. Failure to meet target carries financial penalty, which is accounted for in other risks. Additional governance risk associated with the requirement to meet more stringent screening criteria for Monitor. Risks associated with revised 2013/14 targets from DH: 1) MRSA bacteraemia targets reduced from 2 to 0 avoidable cases (4 cases in 2012/13; 1 considered to be avoidable); failure to meet will effect reputation. 2) C Diff target reduced from 40 to 29 with an incremental financial risk penalty structure	Y	TW	Sep-08	Clinical/Operational	4	4	16	Chief Nurse and Director of Quality & Operations	Apr-15	Detailed annual program of infection prevention and control in place. Robust systems to assist in the early identification and decolonisation of positive patients for MRSA. Full root cause analysis investigation completed for all MRSA bacteraemias within 5 working days to ensure lessons are learned and improvements in practice made. Assurance provided internally through extensive performance reporting including the divisional Performance Dashboards, CMB and Trust Board by the DIPC. External monitoring and reporting to the Area Teams and Quality Surveillance Group against agreed metrics. Antimicrobial Pharmacist in post on all sites - the Clinical Support Division will be managing this risk locally. Enhanced surveillance of any new outbreaks plus additional control measures implemented via regular Outbreak Meetings in conjunction with the Public Health England and by extra ward screening	Monitoring the national and stretch targets to be met through clinical metrics reported to the commissioners and within contract. Monitoring post transrectal biopsy E coli cases. Ensure compliance with Antimicrobial Policy to ensure clinical prescribing of courses of antibiotics are discussed with the microbiologist before prescribed. Auditing against antibiotic prescribing. Nursing staff to ensure compliance with obtaining stool specimens within 72 hours of admission if patient's medical history suggests this is appropriate. NHS England targets for C diff revised with target set for 47 cases for 2014/15. The VitalPac module is now capturing key metrics and performance goals linking with Infection Prevention action plan.	3	3	9	↔