EAST KENT HOSPITALSUNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS – 29 AUGUST 2014**

SUBJECT: **CORPORATE RISK REGISTER – FULL**

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

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 August 2014 with the full Corporate Risk Register (CRR). The top 10 risks on the Corporate Risk Register were last received by the BoD at the June 2014 meeting. This report includes changes that occurred since the last Board meeting. The full register was last presented to the Risk Management and Governance Group (RMGG) on 23 July 2014; the top ten risks were reported on 25 June 2014. The financial risks were also reviewed at the June meeting of the RMGG and are scheduled to be reviewed by the Financial Investment Committee (FIC) in September; an updated report is planned due to the signing of this years' contract. A summary risk report was received by the Integrated Audit and Governance Committee on 05 December 2013.

SUMMARY

There are four risks with an unmitigated risk score of 25 and four with a score of 20. The top eight include, 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; 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 RMGG in July; 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. The CQC draft report has subsequently been received and is subject to review and scrutiny.

New	One	• Reputational risk associated with the publication and findings of the CQC inspection report.
Reduced	One	• Spencer Wing (Healthex Group) purchase – the profits for the last financial year and for the first quarter are being sustained
Increased	Two	• Finance Internal – operational performance – this is driven by Contract Penalties where the Trust's exposure to fines for readmissions and A&E waits has increased • Finance External – Cost and income pressures – The tariff for 2014/15 has been adjusted to reflect an expectation of up-coding and fine avoidance
Substantially changed	Two	• HCAI – Clostridium difficile infections (CDI) increased again in July; the surgical division have exceeded their targets for the year to date

		• A&E performance is still not being achieved against the 4-hour standard
Removed	One	• Adult Safeguarding – recruitment to full establishment, increased staff trained in MCA & DoLS and good use of IMCA service when compared with peers
Emerging	Three	• Trust response to the recently published PHSO report "Time to Act – severe sepsis: rapid diagnosis and treatment saves lives" and the non-compliance with standards following audit. • Patient safety concerns raised by junior doctors working at the Kent and Canterbury site. • Clinical activity exceeding the funded block contract. • Inconsistencies in the recording of patient's known allergies within healthcare records/systems.

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.

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.

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

BOARD 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.

1. Summary

1.1. Explanation

This document provides the Board of Directors (the Board) with the full corporate risk register as at 19 August 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 25 July 2014. The full Corporate Risk Register was received by the Risk Management and Governance Group (RMGG) on 23 July 2014 and the top 10 risks were reported at the last meeting on 25 June 2014. This report includes changes that occurred since the June meeting. 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 block 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 block contract performance will require revision.

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 – 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 risk associated with the delayed implementation of the PACS/RIS
7	54	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service
8	30	Internal – financial operational performance targets
9	53	Trust response to the Reports into the provision of surgical services by the Royal College of Surgeons and the Health Education KSS
10	56	Interim centralisation of the management of high risk and emergency surgery

1.2. Significant changes to the Register since July 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 25 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. Both the Specialist and UC&LTC Divisions are in line with their trajectory; the Surgical Division has reported 10 cases against a total trajectory of 12 for the year. NHS England has revised their objectives and guidance for C difficile infections (CDI) for 2014/15. The key change is the linking of each CDI with identifiable lapses in care. Where there is no link with identifiable lapses in care, there is a proposal that such cases are not considered when contractual sanctions are being calculated; agreement for exclusion must be agreed with the co-ordinating commissioner. A serious incident has been raised recently due to three post 72 hour incidents of C difficile infection, all linked epidemiologically in time and place to Minster Ward. Actions implemented to date include daily visits by Infection Prevention and Control (IP&C) Clinical Nurse Specialists and daily hand hygiene audits.

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

The hydrogen peroxide dry misting cleaning solution has been agreed and the programme is being rolled out to wards.

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 has failed to meet the four-hour standard for April, May, June and July 2014, with performance at 94.7%, 94.5%, 93.8% and 92.44% respectively, which resulted in a failure for the first four months of this financial year. The Trust was again non-compliant with the four-hour A&E standard in July 2014 at Activity levels for the Trust were up by 3.6% on last year, with increased activity at WHH of 4.04% and the QEQMH by 3.5% on last years’ figures. Overall attendances have steadily increased over the past three months, and in July, nearly breached the SPC upper control limit.

A detailed Action Plan and Risk Register has been developed to support the achievement of Quarter 2 and ongoing improvement and achievement of the 4 hour clinical access standard. The key headlines for the action plan are:

- Governance and Policy – a governance and reporting structure has been implemented via monthly A&E Performance meetings to ensure that the Action Plan is being progressed;
- The Operational Plan for the Emergency Floor is being reviewed and will be presented to CMB for ratification;
- A&E Process – Proactive escalation and monitoring of the SECAmb Handover screen is key to the escalation plan;
- Pathways – Joint working with the Surgical Division to review the fractured neck of femur pathway has begun;

- Workforce – Robust and proactive recruitment to ED Consultant and Specialty Doctor vacancies is progressing with an expression of interest from a locum consultant to move into an substantive post. Recruitment to the Acute Physician post is underway with two expressions of interest received;
- Clinical Leadership and Engagement – Dedicated roles and responsibilities have been confirmed with the ED Consultants. ED Matrons are leading the review and actions on breach validation;
- Communication – TV screens will be installed in the ED Waiting Rooms to improve communication around waiting times;
- Information – A&E Report has been developed and is reviewed monthly at the A&E Business Meeting. A breach analysis report is reviewed in the A&E Performance meeting.

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

The plan will highlight support required from external partners and commissioners in order to achieve quarter two. The detailed actions being taken are articulated in the Key National Performance Report.

1.3. **Risks decreased in July 2014 – One**

1.3.1. **Risk 50 – Spencer Wing (Healthex Group) purchase**
A profit of £0.4m was recorded for 2013/14. At month 2 of 2014/15 Healthex Group recorded £0.2m profit. Both these profits were available to the Trust for investment in developing NHS services. The unmitigated risk score is reduced from 9 to 6 on the basis of a reduction in the likelihood of the risk occurring.

1.4. **Risks increased in July 2014 – Two**

1.4.1. **Risk 30 – Financial Internal – Operational performance**

The single largest impact on this risk score is on Contract Penalties where the Trust's exposure to fines for readmissions and A&E waits has increased as Trust performance deteriorates and the CCGs ability and desire to fine increases. However; the proposed contract would allow the Trust to reduce its exposure to such fines but at the expense of the adverse consequence of no payment for over performing its contract unless for extraordinary reasons.

The risk score for unmitigated risk has increased by 11 to 20, but mitigated risk does not change and remains at a score of 4.

1.4.2. **Risk 28 – Financial External – Cost and Income pressures including technical changes**

The increase is due to the more detailed review of the 2014/15 contract and its potential impact on future years with regard to Monitors attitude to the use of tariff. The national tariff has always been used to encourage Trust's into changing behaviour but now this encouragement has moved to cover an expectation of gaming in coding and adjusting or penalising for this matter. This wider use of tariff setting has not been built into the assumptions of the Trusts income in future years.

The proposed contract for 2014/15 and 2015/16 may insulate the Trust a little to this pressure. Also the Trust's drive to reduce length of stay and manage its urgent care pathways more effectively would reduce exposure to this risk category.

The unmitigated risk has increased by 4 to 16 since January 2014 and the mitigated score increased by 3 to 12.

1.5. **Risks removed from the Register in July 2014 – One**

1.5.1. **Risk 42 – Adult Safeguarding**
There is now recruitment to full the establishment of staff including Learning Disability. There are more staff trained in Mental Capacity Act and in the Deprivation of Liberty Safeguards. Across Kent and Medway the Trust refers more patients at risk to IMCA service when compared with peers.

1.6. **Risks added to the Register in July 2014 – One**

1.6.1. The full Care Quality Commission inspection report has been received and published. The findings of inadequate overall and the inadequate for two of the three hospital sites inspected means that the Trust is at risk of being placed into Special Measures by Monitor. A decision has yet to be reached however it appears that the Trust may in breach of its Licence and therefore subject to closer scrutiny from Monitor. The Monitor website is currently indicating that the Trust is "under review" for its Governance Rating and is considering corrective action based on the CQC report findings. The reputational risk to the Trust of these findings is significant and this has been reported onto STEIS because of the media attention that the report has generated locally.

The Trust is required to submit an overarching action plan to the CQC by 23 September 2014, copied to Monitor, addressing all the Key Findings and the areas highlighted as "Must Do's". Further areas of risk may become evident as this action plan is formalised.

The unmitigated risk score is 25, based on the breadth of the potential risks that may become evident, and the mitigated risk score is 20 and makes this the highest risk to the Trust.

1.7. **Emerging Risks – Three**

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

1.7.2. There has been a recent visit to the Kent and Canterbury Hospital (K&CH) 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 follow up visit to the K&CH took place on 15 July 2014; the formal report into the visit has not yet been received. Overall the feedback from trainees was positive and both the GMC and HEKSS were pleased with the results of the visit. The most significant change has been the move from the current model of team-based working to one that is ward-based. A further follow up visit is planned for January 2015.

1.7.3. There was a recent incident where the previously recorded known allergy information was not translated into the current volume of healthcare records. The

case was referred to the Coroner and the Trust is in receipt of a Regulation 28 finding under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. There was a single reference to an allergy recorded in one volume of records embedded within the Surgical Integrated Care Pathway. The type of allergy/sensitivity was not quantified in any way. The allergy was not documented in any prior or subsequent set of healthcare records. No allergy was recorded in the healthcare records held by his GP practice.

Currently, the Special Register on PAS is used to record Patient Allergy information; the descriptor for this states 'refer to notes', as this requires the addition of clinical detail and a decision if the allergy or sensitivity is significant. There is an allergy section on the front of each prescription sheet, which is checked each time the patient receives medication.

The Trust is working on a business case to purchase and implement an electronic prescribing solution; this will include clear referencing of all known allergies and the information can be more accessible for staff prescribing medication. This is an integral component of the Trust's Information Management and Technology strategic plan.

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.

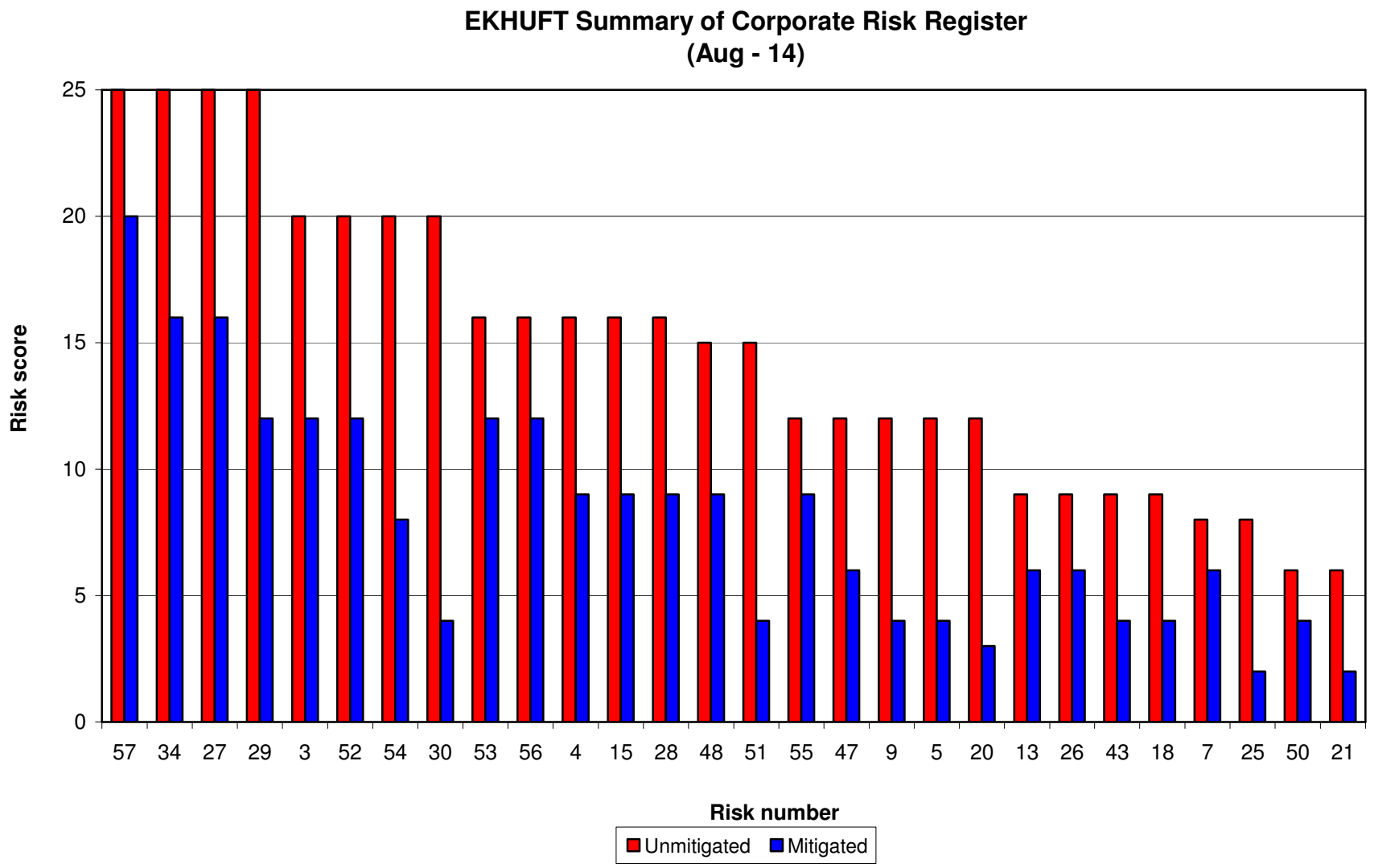
3. The Board of Directors are requested to:

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	57	25	20	Reputational risk to the Trust as a consequnce of the publication of the CQC inspection rpert	Aug-14	
2	34	25	16	A&E performance targets	Apr-14	Giselle Broomes
3	27	25	16	Internal - Financial Efficiency Improvements and Control	Jun-14	Mark Austin
4	29	25	12	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Jun-14	Mark Austin
5	3	20	12	Patient safety, experience & effectiveness compromised through inefficient clinical pathways/patient	Mar-14	Julie Pearce
6	52	20	12	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	Aug-14	Mary Crawford
7	54	20	8	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of	Apr-14	Jane Ely/Obafemi Shokoya
8	30	20	4	Internal - Operational Performance Targets	Jun-14	Jeff Buggle
9	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
10	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
11	4	16	9	Achieving quality standards/CQUINS	Mar-14	Helen O'Keefe
12	15	16	9	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	Mar-14	Sue Roberts
13	28	16	9	External - Cost and Income Pressures including Technical Changes	Jun-14	Mark Austin
14	48	15	9	Patient experience concerns following transition of current Transport Service to a new national provider	Dec-13	Fin Murray
15	51	15	4	Business continuity and disaster recovery solutions for Trust wide telephony	Mar-14	Andy Barker
16	55	12	9	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Apr-14	Jane Ely
17	47	12	6	Winter planning and capacity management	Jan-14	Julie Pearce
18	9	12	4	Loss of clinical reputation due to unmitigated patient safety risks	Oct-13	Michelle Webb
19	5	12	4	Failure to meet 18 weeks RTT	Mar-14	Marion Clayton
20	20	12	3	Compliance with Information Governance Standards	Mar-14	Michael Doherty
21	13	9	6	Age and Design of Trust constraint EKHUFT being top 10 in England	Apr-14	Fin Murray
22	26	9	6	Profile and effectiveness of the clinical audit function	Jan-14	Robin Ufton
23	43	9	4	Embedding Divisional Quality Governance	Jan-14	Helen Goodwin
24	18	9	4	Complexities of Managing the Market	Jun-14	Rachel Jones
25	7	8	6	Incomplete health records (risk re-named and re-scored August 2010)	Dec-13	Marc Farr
26	25	8	2	Management of complaints and patient experience	Mar-14	Sally Smith
27	50	6	4	Spencer Wing (Healthex Group)	Jun-14	Jeff Buggle
28	21	6	2	Blood transfusion process - vulnerable to human error	Mar-14	Angela Green


EKHUFT Summary of Corporate Risk Register
(Aug - 14)
Risk score
25
20
15
10
5
0
57 34 27 29 3 52 54 30 53 56 4 15 28 48 51 55 47 9 5 20 13 26 43 18 7 25 50 21
Risk number
Unmitigated
Mitigated

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

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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-15	Externally facilitated workshop with CCG leads has taken place as a starting point to build better relationships with commissioners. The High level action plan, which needs to be with the CQC by 23 September is in draft. There has been some divisional engagement with the more detailed, local action plans that are required. Discussions are on-going with Monitor on their position and the governance risk rating is none of "under review" until a decision is made.	A series of engagement events with staff have taken place, but more work of staff engagement will be required;; this is being aligned with the We Care programme developments. An interim Improvement Director has undertaken an initial review of the Trust and an Programme manager identified to follow through on the HLAP	5	4	20	New
2	Finance	27	Internal - Financial Efficiency Improvements and Control	Finance and Investment Committee	Trust fails to meet its savings target for 2014/15 and into 2016/17 and without action with Trust will miss its CIP target by more than £5millionWorking Capital may be insufficient to support Trust's investment and capital replacement plan through a reduction of EBITDA compared to plan or increased debt compared to plan. This would also impact on the Financial risk rating for the Trust. Cost control, performance management systems fail to prevent avoidable cost increases and reduced financial efficiency. Delivery of the annual plan is adversely impacted due to delays in the completion of significant service developments. Opportunities to improve efficiency or patient care are delayed reducing profitability and ability to deliver plan agreed with the Board and Monitor. Trust slow to respond to reduced profitability, impacting on achievement of plan and future financial stability.	N	TW	Apr-11	Financial	5	5	25	Director of Finance and Performance	Apr-15	Framework for 3 year rolling Efficiency programme in place. Focus on high value cross cutting themes. Key areas for efficiency improvement identified through benchmarking assessments. Programme Boards, with Executive leadership, formed to manage key corporate improvement areas, e.g. theatre productivity, revisions to patient pathways. Assurance provided through extended gateway process, including tracking system. Routine reporting of planning and performance of efficiency programme through CPMT meetings and Finance & Investment Committee.	CIP stretch target of £30 million planned for 2014/15. Full plan submitted to March 2014 F&IC. Merging the resources of the Programme Office with the Service Improvement team to explore and develop a wider, more effective range of CIP schemes. Likely to benefit from the arrangements being made with CCGsPerformance monitored at monthly meetings and recovery plans produced to confirm full achievement at year end. Savings performance will be against the stretch target	4	4	16	↔
3	Performance	34	A&E performance targets	Board of Directors	The 2011/12 Operating Framework contained a number of new standards relating to A&E performance. These are now used as internal stretch targets and Monitor has reverted to compliance against the four-hour admission/discharge standard for A&E at 95%.	N	TW	Apr-11	Clinical/Operational	5	5	25	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 2014/15, with a view to building on the work undertaken during this winter, especially with regards additional external capacity. Analysis of Delayed Transfer of Care patients is sent daily to Community/Social Service and other Health care providers. EKHUFT have also worked with Social Services to ensure the accuracy of reportable DTOC's as well as the inclusion of a 'working total' to provide an internal early warning system for each acute site. Multi-agency teleconferences are held twice weekly, increasing to daily when under sustained pressure. There has been minimal impact of community schemes for admission avoidance.	Quarterly meetings are held with the Chief Executive, Chairman, Chief Operating Office and the Non-Executive Directors to review the performance of A&E. These meetings are used as a way of discussing the operational issues facing the departments and how to address these. There is an Urgent Care Integrated Care Board which is chaired by Commissioners. The increased pressure recognised throughout the year to date continues. Mitigations include, use of additional agency staff, the direct deployment of GP's in AE and weekend overtime working by senior clinical and managerial staff. There are associated work streams for readmissions, DTOC and the frail elderly pathways. Poor mental health provision - lack of psychiatric liaison service from 24.00 to 09.00 and lack of bed capacity for dementia patients; the Trust is seeking an alternative provider	4	4	16	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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
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	↔
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 & 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	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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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	Chief Nurse and Director of Quality & Operations	Sep-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	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	↔
8	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 and Chief nurse and Director of Quality and 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	↑
9	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. A further review at the K&CH site took place following the CQC inspection. This identified further concerns; the follow up visit in July however showed improvement and the trainees will remain on site. A follow up visit is planned for January 2015	4	3	12	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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10	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	↔
11	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	↔
12	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. The hydrogen peroxide dry misting cleaning solution has been agreed and the programme is being rolled out to wards.	3	3	9	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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13	Finance	28	External - Cost and Income Pressures including Technical Changes	Finance and Investment Committee	Impact of tariff changes on planned activity may vary form the medium term plan. Changes in the pattern of service provision may be adversely affected by future changes in tariff structure resulting in reduced profitability and the Market Forces factor is further reduced in future years. Changing economic and political circumstances undermine the assumptions made in the longer term financial plan	N	TW	Apr-11	Financial	4	4	16	Director of Finance and Performance	Apr-15	Monitor now manage the PbR system. The tariff for 2014/15 has been adjusted to reflect and expectation of upcoding and fine avoidance. This adjustment therefore included a further 0.5% efficiency in the tariff than was planned for last year.	The capped PbR contract for 2014/15 and 2015/16 might insulate the Trust from some of these changes. Controls in place are Board level strategic planning, clinical strategy review, horizon scanning, development of relationships with GP consortia	3	3	9	↑
14	Operational	48	Transport Service delays following transition to a new national provider (NSL)	SD&CP Risk Register	The operational impact following the transition from the EKHUFT PT Service to the new provider (NLS) has resulted in disruption to patient services, delays and poor patient experience. New SLA demands will need to be adopted which challenge existing discharge practices of staff at the front-line. KMCSU have agreed a one year transition period with EKHUFT and the NLS to resolve any problems.	N	TW	Mar-13	Operational	5	3	15	Director of Strategic Planning & Capital Development	Sep-14	The planned transition date of 01 July 2013 occurred with the PTS being run by NSL. The initial staffing issues were mitigated but delays with booking transport still remain with increasing complaints about the service evident.	NSL have a Mobilisation Group led by a designated Mobilisation Director (Kent-Sussex wide) who report to the KMCSU that includes EKHUFT representation from SD&CP. There has been an increasing number of formal complaints about the service since go live on 01 July 2013. This is due to the under estimate by NSL of the resource required across Kent and Medway. An action plan is being managed by West Kent CCG. A new e-booking solution is being rolled out, alongside staff training on the use of the system. Additional internal financial support in place to allow Trust to book PTL outside NSL contract. The Trust provided a fixed provision from December 2013 to the end of March 2014. This was focused on bridging the gap in performance over the winter period and has become more permanent to ease the day-to-day operational pressures experienced at site level.	3	3	9	↔
15	Service	51	Business continuity and disaster recovery solutions for Trust wide telephony	Directorate Risk Registers	The telephony infrastructure and technology is ageing and may lead to difficulties in repairing faults should there be a major component failure. It is highly unlikely that BCP plans will adequately cover a pro-longed outage on any of the core telephone exchanges. This is a specific issue at KCH, which provides services to the switchboard (and Serco service desk), patient service centre and various alarm systems.	N	TW	Jul-13	Clinical/Operational	5	3	15	Director of Strategic Planning & Capital Development	Oct-14	The Trust has recognised that there are unacceptable risks associated with the age and technology utilised by the current telephony infrastructure and that a more modern resilient solution is required. The infrastructure required to support the current disaster recovery plan has not been installed and will require significant investment and network recabling. A project has been initiated to produce a requirements specification and tender for a replacement system, the cost of which is likely to exceed £1.2m for which funding will need to be found.	An operational solution is needed in the short term. The solution is to implement a minimum infrastructure on each site to provide resilient Internet Protocol (IP) telephony to key wards/areas; this is estimated at 50 stations per site and a cost of c £20k depending on final solution. As part of the deployment BCP plans will need to be reviewed to ensure that they remain sound and workable. Capital planning has identified the requisite funding for the upgrade to occur	2	2	4	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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16	Quality and Operations	55	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	Board of Directors	The trust fails to meet performance against the key cancer standards in the 2013/14 National Operating Framework and Monitor Risk Assessment Framework.	N	TW	Apr-14	Clinical/Operational	3	4	12	Chief Nurse and Director of Quality & Operations	Sep-14	The 62 day screening standard has been non-compliance in January and February. There has been improvement in compliance against this target in March but due to the level of non-compliance in January this target will be non-compliant for Quarter 4 end. 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 in March 2014	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.	3	3	9	↔
17	Operations	47	Lack of whole systems response to the winter pressures	BC and EP	There is the potential risk that if our community partners do not maintain efficient patient flow and proactive responses to discharge there will be an impact on the Trust's key targets e.g. A&E 4 hourly wait, mixed sex accommodation, 18 week referral to treatment and Cancer pathways. This could also impact on patient safety and length of stay, as patients face a risk of admitted to beds outside the speciality.	N	TW	Nov-12	Operational	3	4	12	Chief Nurse and Director of Quality & Operations	Mar-15	The Trust and Divisional Winter Plans are robust and are designed to manage the expected Elective and Non-elective activity as per the CAP Plan. Escalation trigger points have been defined, as well as key actions / interventions from the Divisions. The resilience of the internal plans is dependent on the efficient and effective patient flow being maintained throughout the whole system, especially within Social and Community Services. Whilst plans are established to resolve some of these capacity issues during the winter, the significant delays associated with provisions of reablement funding means that external plans are not yet fully established.	Internally - fortnightly Winter Planning meetings to monitor divisional and site responses. Twice weekly Whole Systems Teleconferences with clear ToR to manage bottlenecks & delays. Monthly - Whole Systems Winter plan monitoring group to establish actions to resolve recurring trends. All controls are either in place or are being established, the main challenge is to ensure that the process does not lose momentum throughout the Winter, and that both Social Services and Community remain committed to maintain patient flow. Additional bed capacity identified.	3	2	6	↔
18	Clinical	9	Loss of clinical reputation due to unmitigated patient safety risks inherent within the Trust	PSB, PMB	Potential loss of clinical reputation (caused by poor reliability in quality of care resulting in patient harm or poor clinical outcomes and poor patient experience). Failure to achieve Trust key goals of mortality and harm reduction by 31st march 2015 - related financial impact on CQUIN targets and Never Event cost recovery by commissioning body	N	TW	Sep-08	Clinical/Operational	4	3	12	Medical Director and Chief Nurse & Director of Quality & Operations	Sep-14	Revised Patient Safety Strategy 2011-2015 and Divisional Work plans to integrate current and new initiatives to enable patient safety through the addressing of clinical priorities: handover, the deteriorating patient and Never Events. 2011/12 planned improvements; Vidalia's, Sepsis Steering Group, Improvements in VTE prophylaxis/medicines reconciliation/discharge of the frail elderly (funded project from Health Foundation). 2012/13 Monitoring via the Patient Safety Board with a revised ToR, Divisional Gov Groups and Patient Safety Leads, Clinical Indicators, UK TT, RCA framework, Risk Registers and incident trend monitoring via RMGG	BCG patient safety programme developed and divisional work plans agreed with June BOD 2011. Increased risk initially with responsibility for patient safety resting within the divisions. Revised clinical indicators for the next financial year discussed with commissioning CCGs. Patient Safety - divisional patient safety work plans added to the EPR agenda and to the PSB 6 monthly. This risk links to risk 43 around the divisional arrangements for governance.	2	2	4	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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19	Quality and Operations	5	Failure to meet and sustain 18 weeks RTT	Directorate risk registers	Failure to meet and sustain targets with the result that the Trust could be fined for under performance and that failure to meet the CQUINS gateway could incur a financial penalty	N	TW	Jan-09	Clinical/Operational	3	4	12	Chief Nurse and Director of Quality & Operations	Sep-14	Daily monitoring and management with daily performance update by specialty and backlog to the Executive team with the responsibility with the surgical division. Quarterly update to corporate management team, including NEDs Board to receive all reports from these meetings. Modular theatre on site for orthopaedic activity, with an alignment of the clinical pathway to progress first OP appointment. Additional capacity sought and secured both internally to the Trust and externally within the independent sector. On-going impact assessment to ensure all changes are future proof against revised targets. Controls and improvement work completed and the emphasis now is sustaining the target.	Intensive Support Team modelling of the data clearly outlines the backlog and projections for delivering services against national targets are now clear. Pathways redesigned for high risk specialities to improve efficiencies around capacity. Fortnightly performance improvement meetings with the CCGs commenced and joint improvement plans will be agreed. CCGs informed weekly in order to ensure immediacy of the information they require. Capacity profiling developed, monitored and reported. Out patient PTL in place. Access policy reviewed and AGN plus flow chart developed to reduce the risk of repeated clinic cancellations. Orthopaedic activity currently exceeding contract significantly; this is impacting on the waiting times.	2	2	4	↔
20	Information Governance	20	Compliance with Information Governance Standards	RMGG	The Trust has improved its rating to achieve compliance across the full spectrum of IG standards. However there is a risk that historic evidence needs to be refreshed to maintain compliance in depth in some areas. The latest revision of the IGTK states that the Trust must achieve an annual compliance of 95% for staff training in IG annually.	N	TW	Sep-08	Operational	3	4	12	Chief Nurse and Director of Quality & Operations	Apr-15	The Information Governance Working Group chaired by Deputy Director of Risk Governance and Patient Safety continues to meet monthly to identify gaps and to direct evidence-gathering. The requirement for including IGT compliance is no longer required as part of the self-certification process. However, Department of Health policy is clear that all bodies that process NHS patient information for whatever purpose should provide assurance via the IGT.	A review of the uptake of IG training was undertaken in May-12 and has been presented to the IGSG for action quarterly since this date. The annual internal audit of the IG toolkit V-11 was completed in March 14; a draft report for this years' submission is scheduled at the next IAGC meeting in June 2014. The 2013/14 internal audit has taken place and a draft report received. The single recommendation relates only to the SIRO training. Further action around risk management training for information asset owners is scheduled for 2014.	3	1	3	↑
21	Estates	13	Age and Design of Trust constraint EKH being top 10 in England	Directorate risk registers	The age and design of the Trust's estate is variable, reflecting differing investment patterns over the years. Some investment has resulted in new facilities, parts of the estate are old and may be a constraint in delivering the strategic objective of being one of the Top 10 hospitals in England	Y	TW	Sep-08	Estates	3	3	9	Director of Strategic Planning & Capital Development	Apr-17	The Estates Strategy describes practical investment plans reflecting the needs of key stakeholders, addressing the weaknesses described and the strategic objectives of the Trust. Feb-12. A separate review is currently being undertaken around the Trust's Clinical Strategy which will require a re-prioritisation of the Estates Strategy. However, action has been taken to ensure the likely areas of major capital expenditure which have been reflected in the Trust's Five year Capital Programme. This has been managed within current proposed capital budgets	Once the Clinical Strategy is finished a revision of the Estates Strategy will be brought back to the Board of Directors for agreement	2	3	6	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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22	Performance	26	Clinical Audit	Internal Audit	The recent internal audit identified several areas of improvement specifically around the lack of governance over independent audits being presented externally and greater visibility around clinician engagement with local and national priorities. The audit programme must align with divisional corporate risks and with the external accreditation programmes.	N	TW	Jul-10	Clinical/Operational	3	3	9	Chief Nurse and Director of Quality & Operations	Sep-14	The clinical audit modernisation plan was adopted by the CAEC 6/3/12. Implementation has begun with regular progress reports submitted to the CAEC, with a number of the work tasks being completed and further tasks now being implemented. The attendance at the July CAEC meeting was encouraging and the chair will be monitoring future attendance. The clinical audit policy was adopted the July CAEC meeting and the clinical audit annual report has been drafted and will shortly be circulated to CAEC members for approval. The clinical audit strategy will be submitted to the September meeting of the CAEC. Progress is recorded in the clinical audit modernisation action plan.	The clinical audit policy is now in place. The clinical audit strategy is to be submitted to the CAEC in September 12 for approval. The clinical audit facilitators are now holding a series of meetings with the divisional and speciality clinical audit leads to 1) introduce themselves and explain the support they can provide, 2) agree with the leads arrangements for supporting clinical audit within the division, 3) establishing a more accurate picture of all audit activity within the division. Progress will be reported to CAEC & reports sent to CMB, RMGG & IAGC at regular intervals. The divisional clinical audit dashboard was reviewed at the CAEC in July and a minor amendment agreed. The dashboard is submitted to each CAEC meeting for review by the CAEC. Internal audit review - final report received with an overall rating of green-amber	3	2	6	↔
23	Operational	43	Embedding Divisional Quality Governance	Executive team	Less corporate control of the overall Quality Governance agenda since the move to a Divisional structure. The lack of visible assurance at divisional level against the Quality Governance Framework to inform annual Monitor declaration. Divisional focus on financial and performance management rather than quality.	N	TW	Jul-10	Divisional	3	3	9	Chief Nurse and Director of Quality & Operations	Sep-14	Divisional quality self assessment framework developed and promulgated to all clinical divisions in preparation for completion. Support offered to divisional leadership teams to facilitate completion and alignment of divisional governance meeting to demonstrate compliance.	On-going review of embedding learning within the governance meeting programme in place within some, but not all divisions. External review of divisional governance arrangements planned for the next 2 months starting September 2014Review of the effectiveness of divisional processes planned for April 2014	2	2	4	↔
24	Performance	18	Complexities of Managing the Market	Market assessment	The impact of the development of the Health & Well Being Board/CCG/Commissioning Board and the interplay between these bodies may result in a reduction in income to the Trust. Trust market share may be affected by the complexities of managing the market, or the impact of demand & capacity on referral rates and the potential impact of new entrants. The Trust needs to be flexible with how it manages OPD activity from the sites and this needs to link in with the work undertaken via the Clinical Strategy. There is a also a current lack of intelligence of how the new Health Consortia will operate and the potential differentiation in priorities for each.	N	TW	Sep-08	Services	3	3	9	Director of Strategic Planning & Capital Development	Mar-15	Marketing Assessment agreed by the BoD in February 2012. A marketing Strategy update paper was also presented to the BoD in June 2012. The three year Marketing Strategy was presented to the BoD in Q1 2013. Continued collection and use of market intelligence to maintain n service delivery. Weekly review of referrals received. Maintain relationships with Commissioners	Assessment of market share within some specialties in order to identify changes in referral behaviours. Consideration planned to rationalise the use of Dr Foster and CHKS market share functions planned for May14	2	2	4	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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25	Quality	7	Healthcare records management and clinical documentation	Directorate Risk Registers	Incomplete records impact on the ability of the Trust to ensure that accurate information is used for coding purposes. This impacts financially if the coding data is submitted late for validation by the CCGs. It is also crucial for use in analysing the position of the trust in terms of activity, patient safety and mortality. Lack of available notes for clinic and planned admissions is impacting on patient safety	N	TW	Sep-08	Clinical/Operational	4	2	8	Medical Director and Chief Nurse & Director of Quality & Operations and Director of Finance and Performance Management	Sep-14	Annual PbR coding review and interim external reviews of data quality. National mechanisms to report mortality outliers by the Care Quality Commission and Dr Foster Intelligence. Depth of coding monitored through CHKS, providing national and peer comparative data. Development of electronic discharge system to improve summary information for coding purposes and to improve communication with GPs. Tracking functionality via PAS in place but receipting function not yet operational	Healthcare records and Coding Committees in place with revise Terms of Reference to ensure accuracy, timeliness and completeness of content. Data Quality Policy has been published by the Information team. Programme in place to embed the Data Quality Strategy, monitored corporately on the balanced scorecard. Receipting function is still not working and has been parked until the new PAS is implemented	3	2	6	↔
26	Patient Experience	25	Management of complaints and concerns	Patient Experience Team	The Trust fails to meet the first time response target agreed with complainants and risks increasing levels of dissatisfaction with the internal methods of complaints management	N	TW	Original July 2010 and removed November 2012. Reinstated September 2013	Clinical	2	4	8	Chief Nurse and Director of Quality & Operations	Sep-14	Delegated authority to divisions to respond to formal complaints within the target agreed with the complainant. Monthly reporting of performance to the BoD on the compliance of each division with this target. Monthly review of performance locally at governance meetings on progress to meet complainant satisfaction with current complaints and those open for several months.	Further work required to restructure the PET in order to improve response times, to place greater emphasis on the outcomes of complaints and how these can be effectively fed back to divisions to ensure they are embedded into the organisation to avoid similar problems recurring. Complaints policy to be reviewed to ensure this meets current best practice and that supports the concurrent management of claims and complaints. Align PHSO recommendations with changes to systems and process. Use the feedback and intelligence from the "We Care" campaign. External audit of the response rate to complaints a part of the external review of the Quality Account for 2013/14	2	1	2	↔

Corporate risk register
East Kent Hospitals University NHS Foundation Trust

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27	Clinical Quality and Operations & Finance	50	Spencer Wing (Healthex Group) purchase	Finance and Investment Committee	There are operational and financial risks associated with the recent purchase of the Spencer Wing by the Trust. There is a contractual challenge that could undermine the income projections for the Spencer Wing; reduction in the private patient market since the closure of Pfizer and general economic downturn; higher infection rates for surgical site and Clostridium difficile where fines for performance could be levied as well as the clinical reputation of the organisation being affected; and, decision-making by Spencer Wing managers and staff that expose the Trust to unforeseen costs. The financial risks include: a material error in the evaluation of assets held by Healthex on acquisition; and liabilities being materially larger than stated on acquisition. £0.9 million of the £2.5 million total current liabilities relates to trade creditors with the Trust. There is a further outstanding £0.9 million for consultant medical fees.	N	WHH and QEQM	Apr-13	Clinical/Operational/Financial	3	2	6	Director of Finance and Performance	Sep-14	This risk is being monitored by the Finance and Performance Management Division Governance and through the FIC. There is legally constituted Board of Directors with a Company Secretary in post. Meetings of the BoD are currently taking place monthly. Several members of the Trust BoD are members of the Healthex senior team. The Annual Report and Accounts for 2012/13 has taken the purchase of the Spencer Wing into consideration	No information has become available that changes the risk evaluations made in February over the Healthex Group. A profit of £0.4m was recorded for 2013/14. At month 2 2014/15 Healthex Group has recorded £0.2m profit. Both these profits were available to the Trust for investment in developing NHS services.	2	2	4	↓
28	Clinical	21	Blood transfusion process can be vulnerable to human error	Directorate Risk Registers	Blood transfusion process can be vulnerable to human error. These gaps may result in incorrect identification of the patient and poor traceability of the blood product.	Y	TW	Original Sept-08 Removed April -11. Re-instated Aug-12	Clinical/Operational	3	2	6	Medical Director	Sep-14	Mandatory training programme for staff in line with SPN 14. Right Patient Right Blood'. Currently EKHUFT has a 85% compliance with competency based training. Agency staff are not permitted to collect or administer blood or blood components without being competency assessed by the Transfusion Practitioner team. In order to improve competency assessment further sessions have been secured on the band 5 midwifery training program and the extended practice program for nursing staff who are in their final 3 months of training. Blood transfusion protocols in place across clinical areas for the taking and administering of blood. Standard Operating procedures are in place in Pathology for the processing and traceability of blood products. Traceability figures are collected on a monthly basis via continual audit, traceability is currently 99% across EKHUFT.	All adverse incidents including near misses are subject to a detailed investigation and root cause analysis. Learning from incidents is shared by incorporating vignette in current training programs, articles in risk wise, teaching sessions in handover sessions and ward meetings, accessing clinical audit and governance days and participating in skills drills such as the ones organised by the faculty of trauma and the recent maternity drills. Risks associated with the correct identification of a patient to be further mitigated through the business proposals for the adoption of a positive patient identification system and the use of printed patient wristbands. The business case passed, tender for IT solution completed and system in the process of a phased roll out starting at the WHH	2	1	2	↔