Corporate risk register
East Kent Hospitals University NHS Foundation Trust

Ranked position	Risk Name	Risk Description	Consequences (current)	Likelihood (current)	Risk rating (current)	Executive Lead	Target Date for Completion	Controls in place	Additional Actions/Progress	Consequences (mitigated)	Likelihood (mitigated)	Risk rating (mitigated)	Movement
1	CQC inspection March 2014	The quality, safety, financial and reputational consequences associated with the CQCs' published report into the Trust	5	5	25	Chief Executive	Mar-17	Externally facilitated workshop with CCG leads has taken place as a starting point to build better relationships with commissioners. The High level action plan was sent to the CQC on 23 September 2014. There has been divisional engagement with the more detailed, local action plans that are required. The Trust is in Special Measures with Monitor and subject to a monthly review meeting. A series of diagnostic programmes have commenced; these include divisional governance and data quality. A Ward to Board governance review is also proceeding with a report due in January 2015.	A series of engagement events with staff have taken place, but more work of staff engagement is be required; this is being aligned with the We Care programme developments. An interim Improvement Director has undertaken an initial review of the Trust and an Programme manager identified to follow through the HLIP, supported by an Improvement Plan Delivery Board with staff involvement. A formal Improvement Director was appointed by Monitor and she has overseen the publication of the NHS Choices Action Plan on their website. A clinical lead to support the programme was appointed in November 2014 alongside a dedicated Programme Manager. A cultural change programme is being developed.	5	4	20	↔
2	A&E performance standards	The 2011/12 Operating Framework contained a number of new standards relating to A&E performance. These are now used as internal stretch targets and Monitor has reverted to compliance against the four-hour admission/discharge standard for A&E at 95%.	5	5	25	Interim Director of Operations	Jun-15	There has been financial support in terms of reablement funding which the Trust has been utilising. EKHUFT have been in discussion with Commissioners and Provider Partners with regards reablement schemes and support for 2014/15, with a view to building on the work undertaken during this winter, especially with regards additional external capacity. Analysis of Delayed Transfer of Care patients is sent daily to Community/Social Service and other Health care providers. EKHUFT have also worked with Social Services to ensure the accuracy of reportable DTOC's as well as the inclusion of a 'working total' to provide an internal early warning system for each acute site. Multi-agency teleconferences are held twice weekly, increasing to daily when under sustained pressure. There has been minimal impact of community schemes for admission avoidance.	Quarterly meetings are held with the Chief Executive, Chairman, Chief Operating Office and the Non-Executive Directors to review the performance of A&E. These meetings are used as a way of discussing the operational issues facing the departments and how to address these. There is an Urgent Care Integrated Care Board which is chaired by Commissioners. The increased pressure recognised throughout the year to date continues. Mitigations include, surge resilience funding, additional consultant weekend cover, recruitment to vacant middle grade and substantive consultant posts, increased psychiatric liaison serves and joint post for a critical care paramedic resource at the QEQM for 3 months. The impact of the Perfect Week required evaluation.	4	4	16	↔
3	Internal - Financial Efficiency Improvements and Control	Trust fails to meet its savings target for 2014/15, the £25.2 million and the 2016/17 £9.0 million targets and without action with Trust will miss its CIP target by more than £10 million. Working Capital may be insufficient to support Trust's investment and capital replacement plan through a reduction of EBITDA compared to plan or increased debt compared to plan. This would also impact on the Financial risk rating for the Trust. Cost control, performance management systems fail to prevent avoidable cost increases and reduced financial efficiency. Delivery of the annual plan is adversely impacted due to delays in the completion of significant service developments. Opportunities to improve efficiency or patient care are delayed reducing profitability and ability to deliver plan agreed with the Board and Monitor. Trust slow to respond to reduced profitability, impacting on achievement of plan and future financial stability.	5	5	25	Director of Finance and Performance	Apr-15	Framework for 3 year rolling Efficiency programme in place. Focus on high value cross cutting themes. Key areas for efficiency improvement identified through benchmarking assessments. Programme Boards, with Executive leadership, formed to manage key corporate improvement areas, e.g. theatre productivity, revisions to patient pathways. Assurance provided through extended gateway process, including tracking system. Routine reporting of planning and performance of efficiency programme through Management Board meetings and Finance & Investment Committee.	CIP stretch target of £30 million planned for 2014/15. Full plan submitted to March 2014 F&IC. Merging the resources of the Programme Office with the Service Improvement team to explore and develop a wider, more effective range of CIP schemes. Likely to benefit from the arrangements being made with CCGs Performance monitored at monthly meetings and recovery plans produced to confirm full achievement at year end. Savings performance will be against the stretch target. The focus of control is around ongoing project review and scrutiny from Trust committees and expert technical departments	4	4	16	↔
4	External - CCG Demand Management, Contract Negotiations and Financial Challenges	Movement from block to cost per case for non-elective work increases the risk associated with demand fluctuations, activity capture and competition. Proposed further changes to contract types that could change the balance of risk between commissioner and provider. The transfer of activity to Specialist Commissioning Contracts and Public Health Contracts increases the risk of challenge fro non-payment due to non-commissioned activity	5	5	25	Director of Finance and Performance Interim Director of Operations	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	Patient safety, experience and clinical effectiveness compromised through inefficient clinical pathways, patient flow & delayed transfers of care	Unplanned use of extra beds with un-resourced staffing and patients outlying form their appropriate speciality, which may compromise patient safety and resulting delays	4	5	20	Chief Nurse and Director of Quality & Interim Director of Operations	Apr-15	Managed by General Managers and Senior Site Matrons in post at KCH, QEQM and WHH. Leadership & management programmes are underway to facilitate changes. Monitoring and assurance provided by daily bed meetings (0900hrs, 1600hrs and 1645hrs - UCLTC), weekly operational meetings, fortnightly NEDs meetings to review capacity and flow data, monthly site lead meetings with UCLTC Top Team reviewing length of stay and net admission to discharge ratio (RR) and fortnightly performance improvement meetings chaired by CN&DoQ commenced. Updated weekly to ensure immediacy of the information required. Performance dashboard includes indicators of additional beds and outliers. Review of bed management system currently considering a move to an electronic system supporting real time reporting. The Emergency Care Improvement Programme is in place which covers LOS. This risk is linked to risk number 34 - A&E targets	Bed management review of current systems & group established to review national processes & benchmark current practice. Linked to reduction of additional beds/outliers through improved systems & bed management systems. Medical Director, Chief Nurse & bed holding Divisions reviewing, with consultants & matrons. EC-IST review of whole system, recommendations driving improvements with work programme to support better patient flows. Progress & successes to be measured e.g. Internal Waits Audit, defining Top 10 pathways of care for high risk specialities to improve efficiencies around capacity and reduce readmissions, extending Outpatient Clinic sessions from 3.5hrs to 4hrs, EDD and EDN accuracy and timeliness, qualitative analysis of UCLTC Morbidity & Mortality meetings, review of Discharge and Choice Policy and review of job plans to enable more timely ward rounds. Capacity profiling shows reduction in extra beds & improvements in outliers. Reablement schemes agreed with commissioners to improve flow outside the Trust.	4	3	12	↔

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6	Staff survey and staff engagement	The objective to improve the overall score in the staff survey is not likely to be met. The scores from the staff Friends and Family Test (FFT) showed a deterioration in performance from Q1 to Q2, in the section staff recommending the Trust as a place to work, following the national publication of the CQC inspection reports	4	5	20	Director of HR	Mar-17	The We Care programme has been established for two years and the next step is to commission the services of a partner to support the next steps in the programme. The "delivering our cultural change" was initiated in September 2014. It is anticipated that the programme will take between 18-24 months to complete, but a diagnostic phase is required in order to guide the specific work streams. A preferred supplier has been identified and a culture change programme manager recruited. The programme of staff listening exercises will continue and a revised raising concerns policy approved.	The We Care Steering Group will monitor delivery of the plan, through their monthly meetings, with regular reports to the Quality Board. Local issues and actions will be monitored by Division through the quarterly FFT surveys and executive performance reviews. Collaboration with our external partners to develop and agree overall programme progress "checkpoints", which will include feedback from front line staff and those involved in delivering the programme will take place. This will allow the identification of:- • emerging issues to help the Executive Team identify positive and negative drivers for staff engagement and motivation; • any of quick wins by which senior leadership can demonstrate listening and connection with front line staff; • any changes required to the programme in response to feedback. The success of this programme will be monitored by the Board through the production of a quarterly report, reporting against key milestones and outcomes, evaluating progress and making recommendations on changes as necessary.	4	3	12	↔
7	Difficulty in recruitment of staff against vacancies and national shortages in some hard to recruit posts	There are a number of vacancies within the Trust in nursing, medical and some allied health professionals and, due to national shortages in some of these areas, recruitment has proved problematic because of the competing demands of other organisations. NICE has published guidance on nurse staffing levels in ward areas and plans to publish for A&E	4	5	20	Director of HR	Apr-16	The Trust is finalising the six-monthly review into nurse staffing and acuity; the results of which will be presented at the BoD in January 2015. This includes a review of specialist areas as well as general ward based. The vacancy rate for each professional group is being monitored as part of the CQC Improvement Plan and there are targets agreed for each profession and for key specialty areas e.g. A&E, paediatrics and non-obstetric ultrasound. This will be reported at the monthly Monitor performance review meeting. The Trust is 85% through the £2.9 million investment into staffing, which was approved at the Board in November 2013.	The HR director has reviewed the recruitment pathway and there is a close working relationship with HEKSS and the local Universities to develop innovative approaches to training in some areas to release registered staff from some activities. Board paper on ward/specialist area staffing to BoD in Jan-15	4	2	8	↔
8	Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service	Delays in the provision of sterile chemotherapy drugs resulting in patient safety, patient experience, staff morale and clinical trial activity risks	4	5	20	Director of Pharmacy	Mar-15	The whole service has been closed temporarily whilst the underlying problems are rectified; this includes ordering chemotherapy agents from an external source. A full RCA is being carried out into the whole service and the gaps in service and stock control identified across the pathway. This will be presented to the QAB once complete and the identified action monitored.	Patients kept informed of the changes to the service and redress for extended parking has been paid by the Trust. There is weekly meeting in place between cancer services and pharmacy. The additional stress being experienced by staff is being managed and further support offered. The Qualified Person (QP) for the service has recently resigned. There is provision in place for locum cover whilst a permanent replacement is identified. The phased re-opening of the service has been affected as a consequence	4	2	8	↔
9	Internal - Operational Performance Targets	Trust is fined in year for failure to meet targets such as same sex accommodation, readmissions, delayed Ambulance transfers and non collection of appropriate data.	5	4	20	Interim Director of Operations & Chief Nurse & Director of Quality	Apr-15	The unmitigated consequences are significant and the potential in year impact could exceed £5 million and over the 3 years, exceed £10 million. The single largest contract penalty that the Trust is exposed to is associated with readmissions. The financial range of penalty has been valued at £3-£9 million per annum.	The contract for 2014/15 is based on the Trust's plan, including its own risk evaluation for readmissions being £3 million. The capped PbR contract removes the exposure for the Trust of any greater fine	2	2	4	↔
10	Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates	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	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	↔
12	External - Cost and Income Pressures including Technical Changes	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	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	↔

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13	Effective diagnosis and management of sepsis	The diagnosis of sepsis is sometimes difficult to make, specifically in the young. The standards promulgated by the College of Emergency Medicine and the Sepsis 6/7 model, are the recognised pathways for the treatment of patients. The recent national clinical audit results for the QEQMH and the WHH show that the Trust does not consistently follow these standards of pathways and there is a risk of sub-optimal treatment of patients in some cases	4	4	16	Medical Director	Oct-15	The Trust participated in the recent National Confidential Enquiry into Patient Outcome and Death Sepsis Study, the results are expected next year. The clinical audit programme is being reviewed at divisional level following the findings of the CEM sepsis audit published in August 2014.	Two multi-agency and multi-disciplinary sepsis collaborative meetings have taken place. There is a clearly defined programme of work with leads identified to address the key areas of risk. A Grand Round took place in October 2014, using the pathway maps for patients presenting with severe sepsis; this is to promulgate the learning to date. Further audits of compliance with national standards are being scheduled for adult and paediatric areas. The NHS England "Sign up to Safety Campaign" has focused on an improvement programme in this area, with measureable improvements identified. A bid for a reduction in the NHSLA premiums for 2015/16 submitted. Programme to reduce the safety and financial risks associated with sepsis claims	4	2	8	↔
25	Embedding Divisional Quality Governance	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.	4	4	16	Chief Nurse and Director of Quality	Apr-15	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 2014. Report expected in January 2015 - the likelihood is for further assessment of the robustness of the current arrangements	2	2	4	↑
17	Failure to meet and sustain the admitted 18 weeks RTT	Failure to meet and sustain targets with an inability to meet performance standards in this area. High level of Monitor scrutiny	3	5	15	Interim Director of Operations	Jun-15	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 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 waiting times and an increasing backlog; this has occurred following the de-commissioning of the ICAT service.	3	4	12	↑
14	Aged telephony system is increasingly likely to fail. The supplier will not support the current system after 2017. Business Continuity Plans for each of the Trusts Telephone exchanges (PBX) are inadequate and unworkable for an extended period of time.	In the event of a major outage on any of the exchanges all clinical and non-clinical services would be impacted for an indefinite period of time	5	3	15	Director of Strategic Planning & Capital Development	Dec-16	Procurement of new telephony system is complete. Configuration of the new system has started. Trust wide phone number change has reduced the complexity of the implementation significantly. The project plan shows an 18 month roll out of phones. However this is being reviewed to see if the timescales can be shortened.	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	5	2	10	↔
16	Clinical and patient safety risk associated with the delayed implementation of the PACS/RIS	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	5	3	15	Interim Director of Operations	Feb-15	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. Further upgrades to the system are planned.	4	2	8	↔
18	Failure to meet and sustain the 62 day cancer targets for urgent GP and screening referrals	The trust fails to meet performance against the key cancer standards in the 2013/14 National Operating Framework and Monitor Risk Assessment Framework.	3	4	12	Interim Director of Operations	Mar-15	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	↔

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15	PTS issues impacting on timely discharges and current service provision	The planned termination of the current PTS provider will incur potential disruption to patient transport services and may result in delays in discharge. There is a risk of a deteriorating service during the 12 month notice period and potential mobilisation issues with a new provider (as yet to be determined) following an 18 month procurement process	4	3	12	Director of Strategic Planning & Capital Development	Dec-15	The West Kent CCG accountable officer is leading on plan to a) serve notice b) maintain services during notice period c) re-procure a fit for purpose new service/provider. Stakeholder sessions planned to build new service specification incorporating lessons learnt and Trust CEO feedback. AO to discuss with current provider the daily management of the contract during notice period (provider nominated personal). Monthly verbal update to Trust Board. Budget figure provided to CCGs and Finance for ongoing supplementary site based transport. Maintain internal transport specialist for foreseeable future. Ensure detailed involvement in scoping of new service spec - either service/Trust or geographically specific. Monitor budget to ensure accurate forecast of additional costs. Maintain front door support to ensure discharges are not affected.	Internal stakeholder sessions to reduce Trust delays and cancellations.	4	2	8	↓
19	Lack of whole systems response to the winter pressures	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.	3	4	12	Interim Director of 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	↔
20	Loss of clinical reputation due to unmitigated patient safety risks inherent within the Trust	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	4	3	12	Medical Director and Chief Nurse & Director of Quality	Mar-15	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. 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 QAB	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. Awaiting NHS England's revised Never Event and SI guidance, which may impact on Trust policy and management. Actions linked to Risk 57, with detailed Datix improvement plan in place. Sign up to Safety pledges targeted in 5 main areas - published nationally on website	2	2	4	↔
21	Compliance with Information Governance Standards	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.	3	4	12	Chief Nurse and Director of Quality	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	↔
22	Management of complaints and concerns in order to demonstrate learning	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. The number of written complaints has increased making the timely management more complex	2	5	10	Chief Nurse and Director of Quality	Mar-15	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.	PET restructured 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 2014/15	2	2	4	↔
23	Age and Design of Trust constraint EKH being top 10 in England	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	3	3	9	Director of Strategic Planning & Capital Development	Apr-20	The PEP master planning will identify short, medium and long term development plans. In the meantime the risk adjusted condition survey prioritises the rolling capital programme.	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	↔

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24	Clinical 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.	3	3	9	Medical Director	Mar-15	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 was 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 CAB, QAB & 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 and one minor finding	3	2	6	↔
27	Healthcare records management and clinical documentation	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	4	2	8	Medical Director and Chief Nurse & Director of Quality and Director of Finance and Performance Management	Mar-15	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	Complexities of Managing the Market	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.	3	2	6	Director of Strategic Planning & Capital Development	Mar-15	The latest market assessment was presented to the Board of Directors at the away day in June 2013. This marketing piece supports the previous work presented to the Board on Marketing but provided a focus on the specialities to target in order to secure additional revenue. Areas such as Orthopaedics it is recognised that this will invoke a more strategic discussion because of current demand and capacity issues. The Trust continues to monitor any opportunities and threats, the tender and AQP process and specifically the opening of KIMS at Maidstone. It was agreed that Delivery Plans would be produced by the end of Dec. Preliminary meetings set up with Urology, T&O, Cardiology and ENT during July. A training day is being set up, supported by NHS Elect. For the 7 agreed target specialties, limited progress has been made in T&O and Ophthalmology only. Meetings have taken place in the specialties but there is no appetite to produce delivery plans at this stage. Corporate Tender Team established.	The contract agreed for 13/14 was a managed block and therefore income was fixed and impact of income reduction from our 4 main commissioners mitigated. Demand has increased significantly in 13/14 in some areas including orthopaedics, A/E and 2ww cancer referrals. Good progress has been made in services with substantial capacity gaps. The cardiology business case has been approved, the ophthalmology case is due to go to SIG in Jan 15 and the elective orthopaedic case is being finalised for inclusion in the public consultation as part of Delivering our Future	3	1	3	↓
28	Blood transfusion process can be vulnerable to human error	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.	3	2	6	Medical Director	Mar-15	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	↔