Report to:	Trust Board – Thursday 30th May 2013

Enclosure 5

Title	Governance and Compliance Update: Emergency Planning, Resilience and Response
Sponsoring Executive Director	Debbie Kadum, Chief Operating Officer
Author(s)	Keith Lister, Emergency Planning Officer
Purpose	To update the Trust Board on governance and compliance in relation to business continuity planning
Previously considered by	Not applicable

Executive Summary
This paper informs the Trust Board of changes to Emergency Planning, Resilience and Response requirements for NHS Trusts, and seeks ratification of consequential amendments to the Business Continuity Planning Policy and Strategy.

Strategic Priority	**Operational Objectives**
Quality and Safety	All

Risk and Assurance Issues	The Business Continuity Planning Policy and Strategy supports assurance in relation to mandatory returns to the NHS England via the Shropshire and Staffordshire Area Team.
Equality and Diversity Issues	Delivery of the Business Continuity Planning Policy and Strategy should be undertaken in accordance with relevant legislation and policy in relation to equality and diversity. An Equality Impact Assessment has been undertaken as part of the policy approval process.
Legal and Regulatory Issues	The Business Continuity Planning Policy and Strategy supports compliance with the Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) (Amendment) Regulations 2012 and related legislation and policy.

Action required by the Trust Board
The Trust Board is asked to NOTE the update on Emergency Planning, Resilience and Response.

Update on governance and compliance in relation to business continuity planning

The patients and communities that we serve quite rightly expect our Trust to be there when they need it, irrespective of the circumstances we face. We must therefore do all we can to be well prepared and able to respond to disruptive challenges and emergencies whenever they occur.

Our arrangements for Emergency Preparedness, Resilience & Response (EPRR) assist us in the management of disruptive challenges and emergencies and support continuity of safe, compassionate and effective services for our patients.

During 2012/13 there have been a number of key changes to legislation, policy, guidance and context for NHS Emergency Preparedness, Resilience & Response. These include:

- New legislative requirements pursuant to the Civil Contingencies Act 2004 (Contingency Planning) (Amendment) Regulations 2012
- Delivery of the 2012/13 elements of the Civil Contingencies Enhancement Programme
- The requirement set out in the Health and Social Care Act 2012 for NHS Trusts to identify an accountable Emergency Officer
- Publication of new national NHS Core Standards for Emergency Preparedness, Resilience & Response (NHS England, March 2013) which set out over 100 standards for Acute Trusts
- Changes in NHS structure including the establishment of NHS England (including regional and area teams) and Clinical Commissioning Groups and the dissolution of Primary Care Trusts and Strategic Health Authorities.
- The transition of roles and responsibilities from the Health Protection Agency to the new Public Health England

The Shrewsbury and Telford Hospital NHS Trust's EPRR work programme supports us to embrace and embed EPRR requirements within our policies and practice. Key developments during the year include:

Theme	Current Position
Identification of accountable Emergency Officer	Chief Operating Officer Debbie Kadum is the accountable Emergency Officer for the Trust
Business Continuing Planning Policy and Strategy	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR) require that the Trust has a Board-approved Business Continuity Planning Policy and Strategy. The Trust's Business Continuity Planning Policy and Strategy has been developed to assist in the management of disruptive challenges and emergencies by providing an organisational framework that will increase NHS resilience. This builds on the work carried out to meet the legal requirements placed on the Trust in the Civil Contingencies Act 2004 and Regulations 2005 and 2012. The Business Continuity Planning Policy and Strategy was approved by the Trust in December 2011 and continues to be updated and revised to reflect the latest policy, practice, NHS structure and accountability arrangements. The updated Business Continuing Planning Policy and Strategy is available on request. A key priority for the current year is to ensure that service-level plans are consistent with latest guidance and standards, and that our framework for accountability, testing and improvement is sufficiently robust to support maintenance of service delivery under sustained pressure.
Exercise and Training	A key element of business continuity planning is regular exercises and testing. During 2012/13 the Trust has met its legal requirements for exercise and testing under the Civil Contingencies Act with a multi-agency live exercise in August 2012 and three communications tests.

Quality Standards	The Trust is committed to compliance with the British Standard NHS 25999/ ISO 22301 at the earliest opportunity and the use of the Publicly Available Specification (PAS) 2015: 2010. This is designed to bring together the different stands of resilience planning within the NHS to create a framework that supports the organisation's efforts to become more resilient.
Developing new working relationships	The Trust is working with the Shropshire and Staffordshire Area Team of NHS England and other responders within the local community to ensure continuity of robust EPRR.

The Trust Board is asked to NOTE the update on Emergency Planning, Resilience and Response.

Report to:	Trust Board, 30 May 2013

Enclosure 5(ii)

Title	Board Assurance and Compliance update
Sponsoring Executive Director	Chief Executive
Purpose	The Board Assurance Framework allows the Board to focus on the key risks to strategic objectives To receive the Risk Register
Previously considered by	Risk Committee (May 13), Operational Risk Group (May 13), Audit Committee April 13, Trust Board Feb 13

Executive Summary

The Board needs to be able to provide evidence that it has systematically identified the Trust's objectives and managed the principal risks to achieving them. Typically, this is achieved via the Board Assurance Framework (BAF) document and an embedded risk management approach. At SaTH an outcome-based CQC compliance framework has also been introduced to further assure the Board.

Internal Audit carried out a review of the BAF and risk management process which was presented to Audit Committee in April 2013 that gave 'Substantial' Assurance and stated the were 'confident this provides an adequately designed framework to facilitate robust risk management and assurance arrangements going forward'. There were three Priority 3 recommendations (considered to be of a minor nature, which have all been implemented.

(i) BOARD ASSURANCE FRAMEWORK
Attachment 1 - Board Assurance Framework Summary
This summary shows each risk is categorised by colour according to the current risk matrix

Attachment 2 - Board Assurance Framework
The BAF has been updated in line with the revised corporate objectives. Changes to since the last presentation are indicated in highlighted text. These reflect changes since February and the latest work on strategic objectives and challenges, along with comments received at Risk Committee on 23 May. Some additional assurances have also been added. The full 2013/14 Board Assurance Framework lists the controls in place and sources of assurance, with the lead Director for each risk.

Attachment 3 - BAF Associated Action Plans
A BAF is required to have an action plan. However, there are individual plans for most of the risks on the BAF. Rather than list every item, a schedule of related action plans has been compiled.

(ii) TRUST RISK REGISTER
Attachment 4 - Risk Register Summary
This is a high level summary of ALL the risks on the Centre's registers clustered into themes and by Centre mapped to the BAF risks. These are presented in detail at the Organisational Risk Group. By giving an overall rating for each theme and direction of travel, this highlights areas which are deteriorating to allow increased focus.

Attachment 5 – Trust Risk Register
This gives additional details on the risks which are currently scoring 20 or above. There is one risk scoring 25 (patient flow) and two risks scoring 20. (Table 1) Since the last presentation over 20 risks have been reviewed and the score reduced. Table 2 lists these risks and the rationale for reduction. These were presented to the Risk Committee on 23 May.

(iii) CQC COMPLIANCE

Attachment 6 - Self Assessment against CQC standards-

This report provides an up-to-date status position and comparison with the CQC Quality and Risk Profile (QRP), which the CQC use to assess Trust risk profiles (and is drawn from hundreds of sources of information) highlighting changes month-on-month and showing the direction of travel. Since the last presentation Corporate Outcome leads have been identified. These leads are being trained during May and dashboards for each outcome will be set up to assist oversight. The leads will:

- Provide corporate oversight for the relevant standard
- Provide overall compliance score in relation to Trust intelligence eg incidents, training reports, audit results etc
- Will challenge local self assessments and provide support for action plan development
- Will provide updates on key achievements, concerns and variances in quarter for outcomes rated yellow, amber or red

This attachment shows the current CQC QRP rating for the Trust against each of the outcomes. The latest CQC QRP was issued in April 13. This shows that overall the Trust's self assessment is mainly consistent with the CQC's QRP. There are two main areas of difference which will be particularly important areas for review and challenge by the Corporate Lead:

- Outcome 7 – Safeguarding where the CQC QRP is High Red and SaTH's self assessment is Yellow
- Outcome 14 – Supporting workers, where the CQC QRP is Low Red (the worst score) and SaTH's self assessment is Green. The CQC base their rating largely on the last staff survey which was the Trust's worse for three years and was published in April, which also affects CQC scoring as recency is a factor.

The overall assessment by the Corporate Leads will be ratified by Risk Committee in August.

Related SATH Objectives	**SATH Sub-Objectives**
Related to all SATH objectives	C5. Meet regulatory requirements and healthcare standards

Risk and Assurance Issues	Links strategic objectives to risks, controls and assurances.
Legal and Regulatory Issues	Requirement to support the Annual Governance Statement.

Action required by Trust Board

To **receive** and **approve** the Board Assurance Framework, Trust Risk Register and CQC outcomes assessment

Board Assurance Framework – Summary – May 2013

Key :	↑ Improvement	↓ Deterioration	= No change

	Trend	
QUALITY AND SAFETY – providing the best clinical outcomes, patient safety & experience	=	
• If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience	=	
HEALTHCARE STANDARDS - delivering consistently high performance standards	=	
• If we do not achieve safe and efficient **patient flow** then we will fail the national quality and performance standards	=	
COMMUNITY AND PARTNERSHIP – improving health & well-being of our community through partnership	↑	
• If we do not have a clear **clinical service vision** then we may not deliver the best services to patients	↑	

	Trend	
PEOPLE AND INNOVATION – striving for excellence through people and innovation	=	
• If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve	=	
FINANCIAL STRENGTH – building a sustainable future	↑	
• If **Board members** are not appointed in a timely fashion then this may impact on the governance of the Trust.	=	
• If we do not achieve a **financial risk rating** of 3 then we will not be authorised as a FT	↑	

Risk Matrix

Likelihood	Consequence				
	1 Insignificant	2 Minor	3 Moderate	4 Severe	5 Critical
5 - Almost Certain					
4 - Likely					
3 - Possible					
2 - Unlikely					
1 - Rare					

Board Assurance Framework

May 2013

Attachment 2

Key :	↑ Improvement	↓ Deterioration	= No change

Trust Risk Ref	Lead Director + Category of risk + Lead Cmttee	Principal Risk and Potential Impacts	Inherent Risk	Key Controls	Planned Sources of Assurance + date received/*expected*	Residual Risk rating and direction of travel	Gaps in Control + assurance	Action Lead
Principal Objective QS: Quality and Safety : Providing the best clinical outcomes, patient safety and patient experience								
415	Director of Quality and Safety Safety and Patient Experience Q&S Com.	If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience Potential Impacts: • Avoidable harm to patients • Poor experience for patients • High level of complaints and litigation • Failure to comply with CQC standards • Loss of CQUIN income • Loss of patients to our competitors • Loss of reputation		CQC Compliance Framework (Health Assure) Quality Improvement Strategy and centre's action plans Quality Governance Assurance Framework (QGAF) Incident reporting with RCA and monitoring of actions Consultant revalidation Patient Safety visits to ward Patient Engagement and Improvement Programme (PEIP) work programme Safety Thermometer	Quality component of Integrated Performance Report (monthly) Serious Incident Board Report (monthly) Clinical Quality and Safety Committee which reports to TB (monthly) CQC Compliance Reports- A&E plus 2 follow-up (Jan TB) CQC Patient Survey (Jan TB) Net Promoter (TB monthly) IA Mortality Review (Dec 12 AC) - good progress CCG Quality Assurance visit - Head and Neck - good re privacy and dignity and caring (Jan 13) Cancer Peer Review - Brain and CNS - several areas of good practice and no signficant concerns (Feb 13) Changes made following Rule 43 letter (Feb 13) Acute Trust Quality Dashboard Quarterly (TB Jan 13) Falls Action Plan (TB Feb 13) *QIAs on CIPs reported to Board (Apr 13)*	=	<u>Gaps in Controls</u> • No QGAF action plan • Clinical structure leads to inconsistent application of quality improvements / systems <u>Gaps in Assurance/ Negative Assurance</u> • No consultant revalidation report to Trust Board • Increase in serious patient falls • High no of Grade 3&4 pressure sores • RAID and dementia services not embedded • DNAR audit shows improvement needed (Oct 12) • CCG Quality Assurance visit - Head and Neck - poor re reassessments and decontamination (Jan 13) • External Audit of Hand Hygiene/VTE audit process (Jan 13) • SI reports higher than trajectory (TB Mar 13) • Quality Governance Framework IA Review (Dec 12) • CIP QIA (IA May 13) • National Inpatient survey (April 13)	Director of Quality and Safety Medical Director Director of Quality & Safety

Trust Risk Ref	Lead Director + Category of risk + Lead Cmttee	Principal Risk and Potential Impacts	Inherent Risk	Key Controls	Planned Sources of Assurance + date received/*expected*	Residual Risk rating and direction of travel	Gaps in Control + assurance	Action Lead
Principal Objective HS: Healthcare Standards : Delivering consistently high performance healthcare standards								
561	Chief Operating Officer Patient Flow HEC	If we do not achieve safe and efficient patient flow then we will fail the national quality and performance standards Potential Impacts • Poor /unsafe patient care & experience • Financial penalties • Performance notices • SHA intervention • Failure to achieve FT status • Patients not seen in timely way if outlying • Elective patients not being admitted		Close working with partners in local health economy e.g. frail & complex project Discharge liaison and in-reach from community Improving patient flow project delivery plan Revised bed plan RTT trajectories monitored and corrective action taken Strengthening patient flow & CSM teams (Dec/Jan 13) Scheduling Project to improve access - Booking Centre opened Jan 13 Reconfiguration of available beds	Performance component of Integrated Performance Report to Trust Board monthly - improving access position (Apr 13) Patient Flow Plan TB (Nov 12) *GRR of 1 by June 13* RTT report to TB (Nov 12) Revised bed plan report to TB (Nov 12) Patient flow Update TB (Jan 13) Booking & Scheduling Update (Jan 13) Measures of relative efficiency (TB Mar 13) A&E Compliance (Mar 13) LHE action plan Mar 13 *Step down beds pilot (May 13)* Whole System Improvement Programme ATOS (April 13) Patient Flow Sustainable action plan (TB April) *Winter plan 13/14 (TB June 13)* *Data Quality (Finnamore) Follow up (IA June 13)* *Triangulation of quality and safety information to benchmark the affect of flow management on patient outcomes (May 2013)*	=	Gaps in Control • **Capacity does not meet demand** • FCHS and loss of capacity at PRH • 7 day working not consistently in place • Board rounds not completely embedded • Progress on admission avoidance schemes and early discharge are slower than needed and not yet delivering • Poor clinical operational and administrative system to processes • No surge capacity Gaps in Assurance/ Negative Assurance • Not achieving RTT or A&E targets (TB Mar 13) • Inconsistent achievement of cancer targets	Chief Operating Officer

Trust Risk Ref	Lead Director + Category of risk + Lead Cmttee	Principal Risk and Potential Impacts	Inherent Risk	Key Controls	Planned Sources of Assurance + date received/*expected*	Residual Risk rating and direction of travel	Gaps in Control + assurance	Action Lead
Principal Objective PI: People and Innovation: Striving for excellence through people and innovation								
423	Workforce Director Workforce Workforce Com.	If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve Potential impacts: • Loss of key staff • Poor experience for patients • Adverse ratings in CQC Quality Risk Profile • High sickness absence		Management Development Programme Leadership / Development Academy Appraisals and Personal Development Plan Staff induction linked to Trust values Review Sickness policy Stress risk assessments process for staff Wellbeing Programme	Annual staff survey (Mar/Apr 13) Workforce Reports to Workforce Committee reporting to Board (Feb 13) Cultural Survey (Mar/Apr 13) Positive Deanery visits FY1 and FY2 PRH (Jan 13) Deanery visits FYI and FY2 RSH (Mar 13) Sickness rate decreased (TB May 13) Emergency Medicine Deanery Visit (May 13) *Cultural Transformation Programme (TB July 13)*	=	<u>Gaps in Controls</u> • No overarching Trust Code of Conduct • Poor information relating to medical education / training • Gaps in medical staffing and insufficiently embedded leadership • Nursing education programme needs review <u>Gaps in Assurance/ Negative Assurance</u> • IA review Statutory Training (Dec 12) - limited • Lack of evidence of outputs from Leadership Academy • Poor staff engagement - Staff Survey • Poor attendance at stat training • Staff Survey (April 13)	Workforce Director

Trust Risk Ref	Lead Director + Category of risk + Lead Cmttee	Principal Risk and Potential Impacts	Inherent Risk	Key Controls	Planned Sources of Assurance + date received/*expected*	Residual Risk rating and direction of travel	Gaps in Control + assurance	Action Lead
Principal Objective CP: Community and Partnership: Improving the health and wellbeing of our community through partnership								
668	Chief Executive Officer Strategy Trust Board	If we do not have a clear clinical service vision then we may not deliver the best services to patients Potential impacts: • unsustainable unscheduled care services • Suboptimal use of scarce workforce resource • Avoidable duplication of cost		Structured programme of work to arrive at service delivery models Clinical Service Strategy Group FCHS Group & Project Plan Health Economy Leaders Group	Board consideration of service delivery models (Nov 12 and Feb 13) Outline proprosal for stroke considered by TB Feb 13; submitted to Network and EEAG Cardiology review of non-primary PCI business case - wider review of cardiology service is being considered, business case to be reviewed and updated for consideration by the Board Aug 13 Health and Social Care Compact (TB Mar 13) Trust Development Authority Operating Plan 13/14 - Draft presented to TB March 13, final submission to TDA 6th April 13 - revised finance and workforce model and assurance clarification submitted 30th April 13 *Clinical Services Strategy (July 13)* *Review of emergency departments and ITU - July 2013*	↑	Gaps in Controls and Assurance • No agreed long term clinical strategy but progress being made. Outline proposal to HEC and Board Development session (Feb 13 and Apr 13). Options discussed with clinical lead with regard to impact analysis April 13. Update to CCGs May 13. System Vision- wider stakeholder events planned (June 13) Project Initiation Document (PID) to Board (July 13). Stroke Project Board - review of next steps (May 13)	Director of Business and Enterprise
Principal Objective FS: Financial Strength: Building a sustainable future								
669	Chief Executive Officer Governance Trust Board	If Board members are not appointed in a timely fashion then this may impact on the governance of the Trust. Potential Impacts • Failure to comply with Board Governance Assurance Framework and Board Governance requirements		Appointment Process for Chair	Chairman's update to Board (Apr 13) Medical Director appointed (Dec 12) COO in post (Dec 12) *Chair and 2 NED posts advertised (May 13)*	↑	Gaps in Controls • Permanent Chair not appointed Gaps in Assurance/ Negative Assurance	Chairman Chief Exec
670	Finance Director Financial Finance Com.	If we do not achieve a financial risk rating of 3 then we will not be authorised as a FT Potential impacts: • Inability to invest in services and infrastructure • Impacts on cash flow • Failure to deliver HDD action plan • No QIAs on CIPs reported to Board		Monthly performance review with Centres CIP montoring including QIA process Agency control group established Jan 2013	Financial component of integrated performance report (monthly TB) Reports from Finance Committee which reports to TB FRR of 3 by Jun 13 Reports from Internal and External Audit CIP achieved (TB Mar 13) Income and Debtors (IA Feb 13) Budgetary Control and Financial Reporting (IA Apr 13) Clinical Centres Internal Controls (IA May 13)	↑	Gaps in Controls • No investment strategy to modernise estate, equipment and IT Gaps in Assurance/ Negative Assurance • No agreed QIPP schemes • Historic and ongoing liquidity problem • No 2 year rolling CIP programme • CIP (IA May 13) • Data Quality (IA May 13)	Director of Quality and Safety Finance Director

Attachment 3

Risk Ref	Risk Title	Action plans	Committee	latest update	Lead
415	If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience	▪ Quality Improvement Strategy	Trust Board	Mar-12	DQS
		▪ Quality Governance Framework Action Plan	Trust Board		DQS
		▪ Quality Governance Framework IA Review Action plan	Audit Committee	Dec-12	DQS
		▪ Action plan on recommendations from national inquiries	Trust Board	Jan-13	DQS
		▪ Falls Action plan	Trust Board	Feb-13	DQS
561	If we do not achieve safe and efficient **patient flow** then we will fail the national quality and performance standards	▪ Emergency Access Improvement Plan	Trust Board	Jan-13	COO
		▪ Revised bed plan for 2012/13 and plans to improve patient flow	Trust Board	Nov-12	COO
		▪ Transforming our Booking and Scheduling Systems	Trust Board	Jan-13	COO
		▪ Patient flow sustainable action plan	Trust Board	April-13	COO
		▪ Winter Plan	Trust Board	Jun 13	COO
423	If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve	▪ Staff survey action plan	Trust Board		WD
		▪ Staff training IA Review action plan	Workforce Comttee	Feb-13	WD
668	If we do not have a clear **clinical service vision** then we may not deliver the best services to patients	▪ Future Configuration of Hospital Services	Trust Board	April-13	DBE
		▪ Future Configuration of Hospital Services	Finance Committee	April-13	DBE
		▪ Clinical Services Strategy Update	Trust Board	June-13	DBE
		▪ Reconfiguration of stroke services plan – in draft	Trust Board	Feb -13	DBE
669	**If Board members** are not appointed in a timely fashion then this may impact on the governance of the Trust.	▪ Chairman's update	Trust Board	April-13	Chair
		▪ BGAF action plan	Trust Board	Feb-13	DCG
670	If we do not achieve a **financial risk rating** of 3 then we will not be authorised as a FT	▪ HDD 1 Action Plan	Finance Comttee	Mar-13	FD
		▪ Cash & Treasury Management IA Review Action Plan	Finance Comttee	Feb-13	FD
		▪ Creditors & Payments IA Review action plan	Finance Comttee	Feb-13	FD
		▪ Losses and Special Payments IA Review action plan	Finance Comttee	Mar-13	FD

Trust-wide Summary Risk Register

24/05/2013

Attachment 4

By THEME

			Risk rating (31.10.12)	Risk rating (31.1.13)	Current ratings (15.5.2013)	Overall current rating and trend
PATIENT FLOW	Patient Flow	Red	4	4	4	→
	Total current risks: 16	Amber	5	11	12	
		Green	1	0	0	
	Booking and Access	Red	3	4	1	↑
	Total current risks: 9	Amber	5	4	8	
		Green	2	1	0	
	RTT	Red	7	6	3	↑
	Total current risks: 6	Amber	5	3	3	
		Green	0	0	0	
SAFE CARE	Clinical	Red	3	6	6	↓
	Total current risks: 36	Amber	17	21	29	
		Green	2	1	1	
LEARNING AND GROWTH	Workforce including T&D	Red	19	21	16	↑
	Total current risks: 50	Amber	45	41	33	
		Green	4	1	1	
	Business continuity	Red	1	0	2	→
	Total current risks: 9	Amber	7	10	7	
		Green	0	0	0	
FINANCIAL RISK RATING	Equipment	Red	15	18	14	↓
	Total current risks: 54	Amber	21	24	38	
		Green	6	2	2	
	Estates and Accommodation	Red	17	13	8	↑
	Total current risks: 88	Amber	79	86	77	
		Green	6	4	3	
	Financial	Red	5	2	0	↑
	Total current risks: 3	Amber	3	6	2	
		Green	0	0	1	
	Informatics	Red	5	8	8	↓
	Total current risks: 22	Amber	12	12	14	
		Green	0	1	0	
	Misc	Red	4	2	1	→
	Total current risks: 14	Amber	7	12	13	
		Green	3	1	0	
	Total	Red	78	84	63	↑
	Total current risks: 307	Amber	171	207	236	
		Green	19	27	8	

Total New Risks = 31

Total Risks Closed between 1/2/13 - 15/5/13 = 45

Key : ↑ Improvement ↓ Deterioration = No change

Trust-wide Summary Risk Register

24/05/2013

BY CENTRE

		Risk rating (31.10.12)	Risk rating (31.1.13)	Current ratings (15.5.2013)	Overall current rating and trend
Diagnostics Centre	Red	5	9	10	↓
Total risks: 48	Amber	16	28	37	
	Green	9	1	1	
Emergency and Critical Care Centre	Red	7	7	6	↑
Total risks: 10	Amber	4	6	4	
	Green	2	1	0	
Head and Neck Centre	Red	7	5	0	↑
Total risks: 14	Amber	11	13	14	
	Green	2	0	0	
Medicine Centre	Red	10	6	2	↑
Total risks: 12	Amber	10	9	10	
	Green	1	0	0	
Musculoskeletal Centre	Red	0	2	1	↑
Total risks: 5	Amber	5	2	4	
	Green	1	0	0	
Oncology Centre	Red	2	2	1	↓
Total risks: 9	Amber	2	4	8	
	Green	2	0	0	
Ophthalmology and Patient Access Centre	Red	10	9	7	↑
Total risks	Amber	12	14	19	
	Green	3	0	0	

		Risk rating (31.10.12)	Risk rating (31.1.13)	Current ratings (15.5.2013)	Overall current rating and trend
Pharmacy Centre	Red	2	2	2	→
Total risks: 5	Amber	4	4	3	
	Green	0	0	0	
Surgical Centre	Red	12	14	8	↑
Total risks: 89	Amber	9	13	14	
	Green	4	1	1	
Therapies Centre	Red	4	6	6	→
Total risks: 9	Amber	5	4	3	
	Green	2	0	0	
Women and Children Centre	Red	7	9	7	→
Total risks: 28	Amber	10	16	19	
	Green	5	2	2	
Estates and Facilities	Red	0	2	2	↑
Total risks: 70	Amber	50	70	65	
	Green	15	5	3	
Trust wide & Corporate Depts	Red	29	9	12	↑
Total risks: 48	Amber	42	46	36	
	Green	10	0	0	
Total	Red	85	93	64	↓
Total risks	Amber	152	180	236	
	Green	58	56	7	

Key : ↑ Improvement ↓ Deterioration = No change

Trust-wide Summary Risk Register

24/05/2013

26	307

Key : ↑ Improvement ↓ Deterioration = No change

Table 1: Trust Risk Register Summary Risks scoring 20 or above – May 2013

Centre	Risk Title (ref)	Date added	Last updated	Controlled risk score C x L	Actions on 4risk	Target Date
Emergency & critical care	**Poor patient flow leading to sustained failure to meet A&E target (105)**	**Mar 09**	**Apr 13**	**5 x 5**	**Yes**	**Q3 2013/14**
DQS	Risk of serious injury or death from patient fall (90)	Revised April 13	Apr 13	5 x 4	Yes	Q2 2013/14
Care Group Med Directors	Inability to attract doctors to vacant Deanery or Trust medical posts so making the delivery of the service dependant on agency doctors (537)	Apr 12	Jan 13	5 x 4	Yes	Q2 2013/14

Table 2: Reduced Risk scores (previously scored 20 @ February 2013)

Centre	Risk Title (ref)	Date added	Last updated	Controlled risk score C x L	Reason for reducing score
Ophthalmology & pt access	Poor referral management on SEMA leading to problems with pathway management (342)	Dec 10	Mar 13	4 x 4	SOPs and training programme in place with constant monitoring and feedback
Diagnostics	Insufficient CT capacity to cope with demand impacting on patient flow (595)	Jun 12	Feb 13	4 x 4	Demand and capacity matching in progress
Pathology	Anticoagulation Service caseload above contracted levels causing suboptimal care (346)	Sept 07	Feb 13	4 x 4	Reviewed at Operational Risk Group and revised score agreed.
Therapies	Compromise of therapy for cancer patients following H&N reconfiguration (547)	Jan 12	Mar 13	4 x 4	Rescored following discussion with COO
Diagnostics	Storage facilities in RSH Mortuary inadequate to meet likely increase in workload following reconfiguration of surgical services (633)	Jun 12	May 13	4 x 4	Rescored and combined with existing Estates risk
Medicine	Reverse Osmosis unit at RSH renal unit has insufficient capacity to deliver flow rates for next generation of dialysis machines leading to suboptimal care (500)	Mar 12	May 13	4 x 4	Funding has been allocated over this and next year
Emergency & critical care	Patients of all specialties diverted to Emergency Department due to inefficient patient flow (130)	Jul 09	May 13	4 x 4	Ward reconfiguration and associated changes have improved this issue but still an issue for some specialities at times of peak pressure
Women & Children	Maternity building not fit for purpose (389)	Jun 11	Apr 13	4 x 4	New build in progress – likelihood score reduced as risk now time limited (18 months)
Women & Children	Inability to follow new NICE Guidelines for Neonatal Jaundice in Maternity (598)	Jun 12	May 13	4 x 3	Equipment purchased and Guidelines ready for ratification in May
Women & Children	Insufficient equipment to comply with NICE Jaundice Guideline for in community (660)	Apr 12	May 13	4 x 3	LoF funding necessary equipment which has been purchased and will be in place from 1.6.13

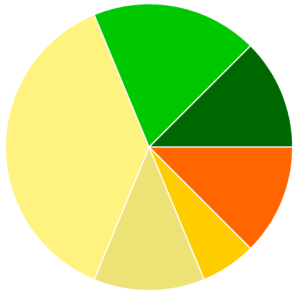
Centre	Risk Title (ref)	Date added	Last updated	Controlled risk score C x L	Reason for reducing score
Ophthalmology & pt access	Unable to develop directory of services to improve Choose and Book due to staffing shortfall (567)	Aug 12	Apr 13	3 x 4	Chose and Book Manager in place with admin support
Surgical	Relocation of Pre Op Assessment at PRH required to improve patient safety (526)	Oct 11	May 13	4 x 3	Area previously occupied by GUM clinic being adapted. Pre Op to move in mid May to early June.
MSK	Non orthopaedic patients on the PRH orthopaedic ward may result in sub optimal care and impact on RTT pathways (133)	Jul 09	May 13	3 x 3	Ward 7 now in place which has increased medical bed capacity and therefore reduced the risk
Ophthalmology & pt access	Outpatient capacity and organisation insufficient to meet demand for services impacting on waiting times (15)	Aug 06	Apr 13	2 x 4	Booking and scheduling task force in place. Capacity planning taken place with centres. New structures and increased admin support
Medicine	Escalation areas opened causing dilution of skills on main wards (489)	Feb 12	May 13	CLOSED	Escalation wards are almost fully established and have been incorporated in to funded baseline.
Workforce Director	Unable to implement new Bank staff database due to ageing IT infrastructure leading to inefficient staff rostering (613)	Feb 12	May 13	CLOSED	'Cloud' based solution implemented - not dependant on IT infrastructure
Estates and Facilities	Telecommunications system ageing and needs replacement to allow modern infrastructure (80)	Nov 08	April 13	CLOSED	Installation of new telecoms infrastructure completed
Surgical	Lack of Endoscopy capacity has increased waiting time to more than 6 weeks (372)	Feb 11	May 13	CLOSED	Waiting times have been met < 6 weeks in March (10% exception for patient choice).
Surgical	Mixed sex accommodation Endoscopy RSH/PRH not compliant with national requirements (488)	Feb 12	May 13	CLOSED	Approval to progress gender separation enabling work at PRH plus the privacy screen at RSH. Tendering process has commenced.
Surgical	RSH DSU is being used for escalation which may result in poor patient experience and outcome and impact on RTT	Sept 12	May 13	CLOSED	This risk has now been closed following the recent internal SAU/AMU/ward reconfiguration.
Surgical	Endoscopy cleaning room (PRH) non compliant with national guidance (662)	Feb 12	May 13	CLOSED	Enabling work to upgrade the decontamination cleaning room to required standards approved. Work due to commence April 13
Surgical	Washer disinfector at PRH cannot be repaired and will impact on RTT if it breaks down (663)	Nov 12	May 13	CLOSED	This has been approved with approx 8 week implementation time
Finance Director	Delays in implementing clinical correspondence project due to lack of IT resource (391)	Jun 11	May 13	CLOSED	Resource secured and project plan in place

2. CQC Essential Standards (Corporate)

The Shrewsbury and Telford Hospital NHS Trust

Corporate CQC Position - Executive Judgement

Overall Corporate Position



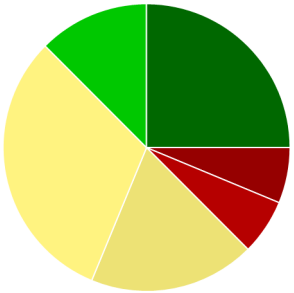
No Data	0
Insufficient Data	0
High Red	0
Low Red	0
High Amber	2
Low Amber	1
High Yellow	2
Low Yellow	6
High Green	3
Low Green	2
Total	**16**

CQC Corporate (QRP Style)	0	0	0	0	2	1	2	6	3	2
Total	**0**	**0**	**0**	**0**	**2**	**1**	**2**	**6**	**3**	**2**

QRP Overview

Overall QRP Rating

High Red



Total Number of Outcomes Assessed	16
High Red	1
Low Red	1
High Yellow	3
Low Yellow	5
High Green	2
Low Green	4

Section 1: Involvement & Information

Outcome	Self Assessment	Outcome Risk Estimate March 2013	Outcome Risk Estimate April 2013
Outcome 01: Respecting and involving people who use services	Green	LOW GREEN	LOW GREEN
Outcome 02: Consent to care and treatment	Green	HIGH GREEN	HIGH GREEN

Section 2: Personalised Care, Treatment & Support

Outcome	Self Assessment	Outcome Risk Estimate March 2013	Outcome Risk Estimate April 2013
Outcome 04: Care and welfare of people who use services	Yellow	HIGH YELLOW	HIGH YELLOW
Outcome 05: Meeting nutritional needs	Green	LOW YELLOW	LOW YELLOW
Outcome 06: Cooperating with other providers	Green	LOW YELLOW	LOW YELLOW

2. CQC Essential Standards (Corporate)

The Shrewsbury and Telford Hospital NHS Trust

Trust Detail

Accountability Title

1. Involvement and Information

G	G	G	Outcome 01: Respecting and involving people who use services *
G	G	G	Outcome 02: Consent to care and treatment *

2. Personalised Care, Treatment and Support

A	Y	Y	Outcome 04: Care and welfare of people who use services *
G	G	Y	Outcome 05: Meeting nutritional needs *
G	G	Y	Outcome 06: Cooperating with other providers *

3. Safeguarding and Safety

A	Y	R	Outcome 07: Safeguarding people who use services from abuse *
G	G	Y	Outcome 08: Cleanliness and infection control *
G	G	Y	Outcome 09: Management of medicines *
G	Y	G	Outcome 10: Safety and suitability of premises *
G	G	Y	Outcome 11: Safety, availability and suitability of equipment *

4. Suitability of Staffing

G	G	G	Outcome 12: Requirements relating to workers *
A	Y	Y	Outcome 13: Staffing *
G	G	R	Outcome 14: Supporting workers *

5. Quality and Management

G	G	G	Outcome 16: Assessing and monitoring the quality of service provision *
A	G	Y	Outcome 17: Complaints *
G	G	G	Outcome 21: Records *

Section 3: Safeguarding & Safety

Outcome	Self Assessment	Outcome Risk Estimate March 2013	Outcome Risk Estimate April 2013
Outcome 07: Safeguarding people who use services from abuse	Yellow	HIGH RED	HIGH RED
Outcome 08: Cleanliness and infection control	Green	LOW YELLOW	LOW YELLOW
Outcome 09: Management of medicines	Green	HIGH YELLOW	HIGH YELLOW
Outcome 10: Safety and suitability of premises	Yellow	HIGH GREEN	HIGH GREEN
Outcome 11: Safety, availability and suitability of equipment	Green	HIGH YELLOW	HIGH YELLOW

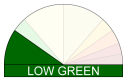
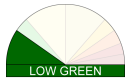
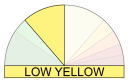
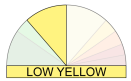
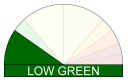
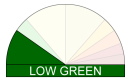
Section 4: Suitability of Staffing

Outcome	Self Assessment	Outcome Risk Estimate March 2013	Outcome Risk Estimate April 2013
Outcome 12: Requirements relating to workers	Green	LOW GREEN	LOW GREEN
Outcome 13: Staffing	Yellow	LOW YELLOW	LOW YELLOW
Outcome 14: Supporting workers	Green	LOW RED	LOW RED

2. CQC Essential Standards (Corporate)

The Shrewsbury and Telford Hospital NHS Trust

Section 5: Quality & Management

Outcome	Self Assessment	Outcome Risk Estimate March 2013	Outcome Risk Estimate April 2013	
Outcome 16: Assessing and monitoring the quality of service provision	Green			→
Outcome 17: Complaints	Green			→
Outcome 21: Records	Green			→