Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PUBLIC – NOVEMBER 2013**

**Agenda Item Number: 225/13**
**Enclosure Number: (9)**

| **Subject:** | Trust Risk Register |
|---|---|
| **Prepared by:**<br>**Sponsored by:**<br>**Presented by:** | Annie Green – Risk Coordinator<br>Julie Dawes – Director of Nursing<br>Julie Dawes – Director of Nursing |
| **Purpose of paper**<br><br>*Why is this paper going to the Trust Board?* | Requires Trust Board guidance<br>Discussion requested by Trust Board<br>Regular Reporting |
| **Key points for Trust Board members**<br>*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals* | Trust Board are asked to note<br>• Top risks<br>• New risk 1.52<br>• Increase of risk 4.3<br>• Decrease of risks 1.46, 4.4 and 4.5<br>• Risk 4.4 re-described |
| **Options and decisions required**<br>*Clearly identify options that are to be considered and any decisions required* | • Review the risks from the Trust Risk Register and consider requirement for further assurance on actions related to significant risks.<br>• Determine any further assurance required on any aspect of the Register |
| **Next steps / future actions**:<br>*Clearly identify what will follow the Trust Board's discussion* | Any decisions with regard to the severity and/or removal of the risks will be reported to RAC and actioned as appropriate in December 2013. |
| **Consideration of legal issues (including Equality Impact Assessment)?** | None |
| **Consideration of Public and Patient Involvement and Communications Implications?** | None |

# RISK REGISTER REPORT

**Purpose:**
To provide the Trust Board with an update on the Trust Risk Register as of 19 November 2013

**Top Risks**

**1.45 ◄► (20):** Lack of internal capacity to maintain acceptable clinical follow up waiting times across ophthalmology and ear, nose and throat.

**1.13 ◄► (16):** Trust fail to achieve objectives for reducing healthcare associated infections

**1.44 ◄► (16):** The trust fails to achieve key local and national access standards and targets.

**1.47 ◄► (16):** Diminished orthotic support has led to delay in patients being able to access the service for new referrals, follow up and review in orthopaedic clinics and MOPRS

**1.48 ◄► (16):** Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate

**1.49 ◄► (16):** At times of high capacity decisions are made to move patients out of their specialty foot print for the provision of their care

**1.51 ◄► (16):** Trust fails to achieve cancer wait targets

**1.52 *NEW* (16):** Implementation of the trust's bed reduction plan

**5.1 ◄► (16):** Achievement of year-end financial position

**1.46 ▼ (15):** Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing

**Risks with Increased Score**

**4.3 ▲ (Amber 9 to Amber 12):** Staff survey results do not improve sufficiently to indicate engagement of workforce and improve position of trust's scores nationally – Q2 Pulse Survey results show slight deterioration

**Risks with Decreased Score**

**1.46 ▼ (Red 25 to Red15):** Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing - likelihood of repeated and prolonged queuing has reduced due to positive impact of and staff engagement in controls

**4.4 ▼ (Red 16 to Amber 12):** Capacity and capability gaps in key management positions both operational and clinical within the Trust – initial risk score deemed too high

**4.5 ▼ (Amber 9 to Yellow 6):** Completion of essential skills training falls below the level acceptable to Trust Board – (85% with information governance requiring 95%) – Achieved over 85% compliance for three consecutive months

**New Risks**

**1.52 *NEW* (Red 16):** Implementation of the Trust's bed reduction plan

**Risks to be Removed**

**Nil**

**Target Date Changes**

**Nil**

**Of Note**

Risks 4.4 re-written to fully describe current issues

**Prepared by:** Annie Green – Risk Coordinator

**Presented by:** Julie Dawes – Director of Nursing

# Trust Risk Profile - November 2013

| LIKELIHOOD (frequency) | CONSEQUENCE (impact/severity) | | | | |
|---|---|---|---|---|---|
| | **Insignificant (1)** | **Minor (2)** | **Moderate (3)** | **Major (4)** | **Extreme (5)** |
| **Rare (1)** | | | | | |
| **Unlikely (2)** | | | 4.5 Essential Skills training ▼ | 1.32 Non adherence to safe haven policy ◄ ►<br>1.33 ◄ ► Misidentification of blood samples | |
| **Possible (3)** | | | 1.31 Impact of software upgrades◄ ►<br>1.34 Non-Luer spinal devices ◄ ►<br>1.43 Sewage flooding ◄ ►<br>3.1 Provision of discharge summaries to GPs ◄ ►<br>4.1 Increased vacancies and NHSP fill rate◄ ►<br>4.2 Staff appraisal ◄ ► | 1.3 Use of Non-Buying Solutions agencies◄ ►<br>1.4 Access to specialist mental health assessment◄ ►<br>1.25 Loss/disclosure of PID ◄ ►<br>1.28 Fire risk assessments ◄ ►<br>1.29 Fire awareness training ◄ ►<br>1.38 Risk of patient injury following inpatient falls ◄ ►<br>1.40 Quality requirement◄ ►<br>1.41 Unintended consequences of CIP◄ ►<br>1.5 7 day Working ◄ ►<br>4.3 Staff survey results ▲<br>4.4 Management capacity ▼<br>5.2 Cash Liquidity ◄ ► | 1.46 ED queue and Trust bed capacity ▼ |
| **Likely (4)** | | | 1.42 Concerns with Health Record function ◄ ► | 1.13 Healthcare associated infection trajectories ◄ ►<br>1.44 National and local targets ◄ ►<br>1.47 Orthotics Service ◄ ►<br>1.48 Data Quality ◄ ►<br>1.49 Outliers ◄ ►<br>1.51 Cancer wait targets ◄ ►<br>1.52 Bed reduction ***NEW***<br>5.1 Year end financial position ◄ ► | 1.45 Service delivery issues Ophthalmology & ENT ◄ ► |
| **Highly Likely (5)** | | | | | |

# TRUST RISK REGISTER 2013/14 – PROGRESS SUMMARY – NOVEMBER 2013

| STRATEGIC AIM Executive Lead | OPERATIONAL LEAD RESPONSIBLE COMMITTEE | | PRINCIPAL RISK (Obstacle to achievement of strategic aim) | CQC OUTCOME REFENCE | PROGRESS MONTH ON MONTH | | | | | | | | | | | | | Review Date | Target (residual) risk score/date to achieve |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | | |
| 1. Deliver safe, high quality, patient centered care | RK SMT | 1.3 | Use of Non Government Procurement Services approved staffing agencies | 4 | TOLERATE | | | | | | | | | | | | | Dec 13 | 12 |
| (Director of Nursing) | SB SC | 1.4 | Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode | 7 | TOLERATE | | | | | | | | | | | | | Dec 13 | 12 |
| | CM ICMC | 1.13 | Trust fail to achieve objectives for reducing healthcare associated infections | 8 | 16 | 16 | 16 | 20 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | | Dec 13 | 16 Mar 14 |
| | JT IGSG | 1.25 | Potential loss /misdirection/inappropriate disclosure of personal data. | 1 | TOLERATE | | | | | | | | | | | | | May 14 | 12 |
| | GH F & S C | 1.28 | Lack of technical risk assessment and remedial works results in failure to comply with the regulatory reform (fire safety) order 2005 | 10 13 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | | Dec 13 | 3 Apr 14 |
| | GH F & S C | 1.29 | Inability to ensure all staff receive fire awareness training results in failure to comply with the regulatory reform (fire safety) order 2005 | 10 13 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | | Dec 13 | 2 Mar 14 |
| | CT IGSG | 1.31 | Software upgrades of major IT systems impact on the Trust's ability to operate and report, due to bugs and/or changed features that are incompatible with the way the system is used in the Trust | 11 | 9 | 9 | 9 | TOLERATE | | | | | | | | | | Feb 14 | 9 |
| | JT IGSG | 1.32 | Requirement to balance data protection and clinical risk factors from adherence to the Safe Haven Policy (faxing confidential information) | 1 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | | Dec 13 | 4 Mar 14 |
| | SS CS Gov | 1.33 | Misidentification of blood samples sent to the laboratory – Indicating patient was not identified at the bedside | 4 | 8 | 8 | 8 | 8 | 16 | 16 | 16 | 16 | 16 | 8 | 8 | 8 | | Dec 13 | 4 Dec 13 |
| | SE MDMC | 1.34 | NPSA alert demands that all spinal devices are non-luer by April 1st 2012. This is to reduce risk of accidental misconnection with other, ie intravenous devices. Non-luer devices did not exist at the time of the alert | 4 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | | Jun 14 | 3 Jun 15 |
| | JW PSWG | 1.38 | Risk of patient injury following inpatient falls due to failure to follow policy | 4 | | | | | | 12 | 12 | 12 | 12 | 12 | 12 | 12 | | Dec 13 | 8 Mar 14 |
| | LW G&Q | 1.40 | Failure to achieve internal and external set quality requirements | 4 | | | | | | | | 12 | 12 | 12 | 12 | 12 | | Dec 13 | 8 Apr 14 |
| | LW G&Q | 1.41 | Unintended consequences to delivery and quality of care due to cost improvement programme | 4 | | | | | | | | 12 | 12 | 12 | 12 | 12 | | Dec 13 | 8 Apr 14 |
| | AF RAC | 1.42 | Concerns with health records function | 4, 13 | | | | | | | | 15 | 15 | 12 | 12 | 12 | | Dec 13 | 6 Nov 14 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | | |
| | JA CCRG | 1.43 | Blockage of sewage services leading to flooding within departments, predominantly Paediatrics | 10 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 9 | 9 | 9 | 9 | | Jan 14 | 6 Review Jan 14 |
| | MM SMT | 1.44 | The Trust fails to achieve key local and national standards and targets. | 4 | 16 | 16 | 16 | 9 | 9 | 9 | 9 | 9 | 16 | 16 | 16 | 16 | | Dec 13 | 9 Apr 14 |
| | NM SMT | 1.45 | Lack of internal capacity to maintain acceptable clinical follow up waiting times across ophthalmology and ear, nose and throat.<br>Back log of patients waiting for follow up.<br>Lack of commissioner engagement to assist management of situation (eyes)<br>Lack of community capacity in which to discharge stable patients | 6 | | | | | 25 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | | Dec 13 | 10 Apr 14 |
| | MP SMT | 1.46 | Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing | 4<br>15 | 20 | 20 | 20 | 20 | 20 | 25 | 25 | 25 | 25 | 25 | 25 | 15 | | Dec 13 | 15 Nov 13 |
| | HW RAC | 1.47 | Diminished orthotic support has led to delay in patients being able to access the service for new referrals, follow up and review in orthopaedic clinics and MOPRS | 4 | | | | | | | | | 20 | 16 | 16 | 16 | | Dec 13 | 8 Jan 14 |
| | PM AC | 1.48 | Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate | 16 | | | | | | | | | 16 | 16 | 16 | 16 | | Dec 13 | 8 Apr 14 |
| | GP SMT | 1.49 | At times of high capacity decisions are made to move patients out of their specialty foot print for the provision of their care | 4 | | | | | | | | | 16 | 16 | 16 | 16 | | Dec 13 | 8 Apr 14 |
| | SH SMT | 1.50 | Lack of equivalent workforce across seven days of the week | 4 | | | | | | | | | | 12 | 12 | 12 | | Jan 14 | 8 review Jan 14 |
| | MM SMT | 1.51 | Failure to achieve cancer wait targets | 4 | | | | | | | | | | 20 | 16 | 16 | | Dec 13 | 10 Apr14 |
| | JD SMT | 1.52 | Implementation of the trust's bed reduction plan | 4, 26 | | | | | | | | | | | | 16 | | Jan 14 | 8 Apr 14 |
| 2. Develop a reputation for excellence in innovation, research & development and education in the top 20% of our peers.<br>(Medical Director) | | | | | | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | | |
| 3. Become the hospital of choice for general, specialist and selected tertiary services<br>( Chief Operating Officer) | SH<br>G&Q | 3.1 | The Trust requirement to use Vitalpac to generate an electronic discharge summary for all patients is experiencing delays in implementation | 4 | 6 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | | Dec 13 | 6<br>Apr 14 |
| 4. Staff would recommend the trust as a place to work and receive treatment<br>( Director of Workforce and Organisational Development) | NL<br>NW/HR R C | 4.1 | The NHSP/agency fill rate has decreased slightly (80 %) the gap is registered nurses. This resulting gap, can be critical within some high demand and acuity areas – ED, acute wards.<br>Aggressive recruitment continues however march – sep is a difficult time to recruit large numbers | 13 | 12 | 12 | 12 | 12 | 12 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | | Jan 14 | 9<br>review<br>Jan 14 |
| | RK<br>SEC | 4.2 | Completion of staff appraisals falls below the level acceptable to the Trust Board – 85% | 13 | 12 | 12 | 12 | 9 | 9 | 9 | 6 | 6 | 6 | 9 | 9 | 9 | | Dec 13 | 6<br>Mar 14 |
| | TP<br>SEC | 4.3 | Staff survey results do not improve sufficiently to indicate engagement of workforce and improve position of trust's scores nationally | 13 | | | | | | | | | 12 | 9 | 9 | 12 | | Jan 14 | 6<br>Apr 14 |
| | TP<br>RAC | 4.4 | Capacity and capability gaps in key management positions both operational and clinical within the Trust | 13 | | | | | | | | | | 16 | 16 | 12 | | Jan 14 | 8<br>Mar 15 |
| | TP<br>RAC | 4.5 | Completion of essential skills training falls below the level acceptable to the trust board – 85% with information governance requiring 95% | 13 | | | | | | | | | | 9 | 9 | 6 | | Jan 14 | 4<br>Mar 14 |
| 5. Develop sufficient financial strengths to adapt to change and invest in the future<br>( Director of Finance and Investment) | BM<br>FC | 5.1 | The Trust is unable to achieve its planned year end financial position 2012/13 | 26 | 20 | 16 | 20 | 16 | 12 | 12 | 16 | 16 | 16 | 16 | 16 | 16 | | Jan 14 | 12<br>Apr 14 |
| | BM<br>FC | 5.2 | The trust is unable to maintain sufficient liquidity/cash | 26 | | | | | | | | | 12 | 12 | 12 | 12 | | Jan 14 | 9<br>Apr 14 |

| | Reflected on or linked to Assurance Framework | | Existing Risks | New Risks | Risk reduced / recommended for local monitoring | | |
|---|---|---|---|---|---|---|---|
| TYPE (may be more than one type) | C = Clinical | F = Financial | H&S = Health & Safety | L = Legal | Q&P = Quality / Performance | R = Reputation | SD = Service Delivery |
| SOURCE | Incident | Assessment | Escalation from other register | CAS Alert | Other – please specify | | |
| Risk scores are calculated by | Consequence I x Likelihood (L) using the 5 x 5 matrix | | | | | | |
| TARGET DATE – RAG RATED FOR PROGRESS | ON TARGET | | MINOR OBSTACLE TO ACHIEVING TARGET | | INABILITY TO ACHIEVE PREDICTED TARGET | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | On target | | |
| | | | | | | | | | | | Minor obstacle to achieving target | | |
| | | | | | | | | | | | Inability to achieve predicted target | | |
| | | | | | | | | | | | Review Date | Target Date | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Review Date | Target Date | |
| 1.3<br>4<br>(4.3) | R / H & S / L – Assessment | 18/08/07 | USE OF NON-GOVERNMENT PROCUREMENT SERVICES APPROVED STAFFING AGENCIES:<br><br>Recent audit found that one third of all invoices paid between November 2011 and October 2012 were non GPS framework agencies. The figures provided by finance include self employed individuals and some service providers.. | • Full/ appropriate engagement checks may not be in place when using such agencies putting patients and staff at risk of harm.<br>• Potential for agencies to be charging rates higher than GPS framework agencies.<br>• Potential for self employed individuals to be working on incorrect contractual terms, potential issue regarding National Insurance and tax payments. | • Executive Director approval needed for all temporary staffing requests<br>• Use of non-GPs agency staff restricted via Temporary Staffing Team (TST). Currently no non-GPS approved agencies are utilised<br>• TST bookings undertake all possible checks<br>• Clinical areas alerted when non-GPS staff engaged via TST and risk reduction measures taken, where required e.g. close supervision<br>• Policy amended to reflect requirement to notify ISA, guidance completed and included in all relevant HR policies<br>• Instructions issued regarding correct process for procurement of self employed individuals to ensure they are engaged correctly and for booking temporary staff<br>• Workforce Review meetings held with each CSC, HR and Finance on fortnightly basis to discuss temporary staffing usage and assurance<br>• Procurement monitoring | **12**<br>**4X3** | **12**<br>**4X3** | **12**<br>**4X3** | • Cannot eliminate risk, but effectiveness of controls to be kept under review.<br>• Approval given by EMT and SMT to pursue outsourcing of temporary staffing team. KPI's and contract to be developed to ensure provider can deliver – working group set up to implement now developed<br>• Part of outsourcing to ensure no booking can be made by any CSC directly with any agency<br>• New GPS Framework published 1st July 2013 - arrangements are different than previous framework, Procurement and TST setting up new contracts with individual agencies used by Trust. Will include assurance on pre-employment checks and costs. Temporary arrangement prior to outsourcing of TST.<br>• Audit undertaken by Deliotte in June 2013. Recommendations and action plan being developed<br><br>**TOLERATE** | • HR monitoring of agency staff in bi-weekly monitoring meetings wth CSCs.<br>• Audit Committee to monitor audit recommendatio ns and action plan | Dec<br>2013 | N/A | Rebecca Kopecek<br>**SMT** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Review Date | Target Date | |
| 1.4<br>7<br>(1.4) | C / H & S / SD – Assessment | 01/04/08 | LACK OF URGENT ACCESS TO SPECIALIST MENTAL HEALTH CLINICAL ASSESSMENT AND ADVICE FOR PATIENTS WHO ARE HAVING AN ACUTE EPISODE IN GENERAL HOSPITAL | • Patient and staff safety | • Mental Health Team liaison presence in ED for patients who present having self-harmed or for whom ED medics consider a mental health assessment is required.<br>• Liaison team in place between 10:00 and 23:00; considered appropriate for activity<br>• Mental health in acute setting on junior doctors rolling educational programme<br>• Alcohol liaison service team MAU/ED<br>• Mental Health<br>• 1.5 wte learning disability liaison service resource supplied by Southern and Solent Healthcare | 12<br>4X3 | 12<br>4X3 | 12<br>4X3 | • 10 places secured for combined RN/Mental Health training (pre-reg)<br>• Older Persons Mental Health pilot funded until end of Jun 12 – extended to March 14. Once completed pilot results to be shared with Commissioners for funding consideration. (continues to be under review)<br>• Portsmouth City Integrated Commissioning Unit undertaking whole system review of mental health liaison and consulting with PHT clinical teams<br>• Gain clarity on commissioning intentions going forwards as a result of the above<br>• Review and re-issue policy and practice guidance for de-escalation and restraint – to be ratified by safeguarding committee chaired by DoN<br><br>**TOLERATE** | • Mental Health and Learning Disabilities Group<br>• Complaints and incidents – monthly exception report and quarterly quality performance report. | Dec 2013 | Apr 2014 | Sarah Balchin<br>**SC** |

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| | | | | | | | | | | | Review Date | Target Date | |
| 1.13<br>8<br><br>(1.2<br>&<br>1.4) | C / R / Q&P – Assessment | May 2012 | TRUST FAIL TO ACHIEVE OBJECTIVES FOR REDUCING HEALTHCARE ASSOCAITED INFECTIONS;-<br>Failure to meet objective of 0 (zero) cases of avoidable MRSA bacteraemias<br>Failure to meet objective of 30 hospital acquired cases of Clostridium difficile infection<br>Failure to reduce hospital acquisition of other health care infections e.g. MSSA (methicillin sensitive staph aureus), E.coli bacteraemias etc<br>Failure to control spread of multidrug resistant infection e.g. VRE (vancomycin resistant enterococci), ESBLs (extended spectrum beta lactam producing<br>Increased incidents of MRSA colonisation on NICU, predominance of unique MRSA strain 15b1 | • Failure to meet quality performance indicators for CCGs, TDA<br>• Failure to meet objectives results in financial penalties.<br>• Failure to meet CQC standards (outcome<br>• Increased patient morbidity and mortality, readmission rate and LOS<br>• Decreased patient experience<br>• Loss of public and professional reputation<br>• Increase in litigation and complaints (numbers and costs)<br>• | • Monthly board exception report, annual DIPC report to the board.<br>• Weekly infection dashboard to all CSCs<br>• Daily list of infected patients to matrons<br>• Daily list of overdue devices to all consultants and senior nursing staff<br>• Feedback of infection metrics at HoNs & NMAC meetings<br>• Multidisciplinary participation at ICMC and RCAs for all sentinel infections<br>• Infection prevention data on weekly kitbag and heat map data<br>• Mandatory infection prevention training for all staff<br>• Feedback and teaching to all staff disciplines<br>• Participation at CSC governance and MM meetings<br>• Prominent hand hygiene prompts throughout Trust<br>• Infection prevention in all staff contracts<br>• Participation in surveillance schemes to allow benchmarking of Trust performance<br>• Targeted surveillance (real time) of HCAIs<br>• Emergency outbreak meetings on NICU colonisations | 12<br>4x3 | 16<br>4x4 | 16<br>4x4 | • MRSA action plan<br>• Infection Control priorities 2013/14<br>• Action plans and learning from multi-disciplinary RCAs<br>• Action plans to address specific CSC issues<br>• C.Difficile Work plan<br>• NICU remedial action plan | • Monitored by ICMC. TB and CSCs clinical dashboards<br>• Reports to Clinical Governance, RAC and PSWG<br>• Daily list of overdue IV devices<br>• Weekly infection dashboard<br>• Weekly or bi-weekly presentations to Head of Nursing.<br>• Monthly exception reporting to Trust Board<br>• Quarterly report to CCGs<br>• MRSA exception reporting at IPMC | Dec 2013 | Mar 2014 | Simon Holmes, Caroline Mitchell,<br>**ICMC** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Review Date | Target Date | |
| 1.25<br>1<br>(1.1) | C, F, L, Q&P, R, SD / Assessment | 28/3/08 | POTENTIAL LOSS / MISDIRECTION / INAPPROPRIATE DISCLOSURE OF PERSONAL DATA:<br>▪ E-mail<br>▪ Direct electronic transfer<br>▪ Post | ▪ Breach of confidentiality (unauthorised disclosure)<br>▪ Damage / distress to individuals affected<br>▪ Potential legal action against Trust<br>▪ Damage to Trust reputation<br>▪ Loss of confidence in Trust services<br>▪ Potential regulatory action including financial penalties (up to £500k) | • Applicable Trust policies and policy compliance monitoring activities<br>• Encryption of removable media / e-mail tools available / use of NHSMail promoted and within policy<br>• User accounts and passwords / password changes<br>• Password protected screensavers<br>• Deviation from certain expected practices must be agreed through RAC (i.e. encryption) | 16<br>4X4 | 12<br>4X3 | 12<br>4X3 | No material changes to risk<br>TOLERATE | • Reporting of compliance to IGSG<br>• Ongoing monitoring through the Information Governance Compliance Framework<br>• Incident analysis and reporting<br>• Process for accepting certain kinds of risk (e.g. unencrypted devices) formalised | May 2014 | N/A | James Taylor<br>**IGSG** |

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| | | | | | | | | | | | Review Date | Target Date | |
| 1.28<br>10<br>13<br>(1.2) | H&S / L / R – Risk Assessment | Mar 2010 | LACK OF TECHNICAL RISK ASSESSMENT AND REMEDIAL WORKS RESULTS IN FAILURE TO COMPLY WITH THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 | • Trust receives enforcement or prohibition notices<br>• Compromised health and safety of patients and staff – injury, loss of life<br>• Loss of premises and service disruption | • Technical advice provided by Trust Development Team<br>• Risk assessment and response plan for some areas<br>• Technical risk assessments completed in retained estates and peripheral buildings | 15<br>5x3 | 12<br>4 x 3 | 3<br>3x1 | • Undertake identified remedial works<br>• To be included in CSC performance reviews<br>• CSL have extended completion of works timetable<br>• Technical risk assessments by CSL completed in Retained estate (old build) and peripheral buildings. New build risk assessments under way and due to be completed by Sept 2013 in line with Hants Fire & rescue request<br>• Occupational risk assessments by PHT 90% complete.<br>• Works identified by risk assessment underway as part of lifecycle maintenance. (D level to be completed by Oct 2013 if lifecycle works continue into the winter E level will be completed by April 2014).<br>• Scale of works identified are large. Until the majority of these remedial works are completed risk will remain at approximately the same level | • Monthly department performance reviews<br>• Register of local fire assessments<br>• Local 'Fire' books<br>• Regular review by HFRS<br>• To date Trust has passed inspections without notification. | Jan<br>2014 | Apr<br>2014 | R Burns / J Acourt<br>**F&SG** |

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| 1.29<br>10<br>13<br>(4.1) | H&S / L / R – Risk Assessment | Mar 2010 | INABILITY TO ENSURE ALL STAFF RECEIVE FIRE AWARENESS TRAINING RESULTS IN FAILURE TO COMPLY WITH THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 | • Trust receives enforcement or prohibition notices<br>• Compromised health and safety of patients and staff – injury, loss of life<br>• Loss of premises and service disruption | • Fire Safety Adviser post recruited to and inducted.<br>• Training provision revised for interim fast track improvement by EO December 13 (expecting slippage).<br>• Further improvements identified and courses under development for delivery 2014/15 | 15<br>5x3 | 12<br>4 x 3 | 2<br>2x1 | • Complete training for all Trust and Carillion staff<br>• Assessment of training requirements by area: questionnaire sent to all areas<br>• To be included in CSC performance reviews<br>Update<br>• 2700 staff already trained, all staff will need to be trained by March 2014. Availability of training on track to achieve target date<br>• The risk is that staff are not released to attend face to face training. | • Monthly department performance reviews<br>• Record of staff undergoing training<br>• Regular review by HFRS<br>• To date Trust has passed inspections without notification | Jan 2014 | Mar 2014 | R Burns / J Acourt<br>**F&SG** |

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| 1.31<br>10 | C, F, Q&P, R – Assessment | Sep 2012 | SOFTWARE UPGRADES OF MAJOR IT SYSTEMS IMPACT ON THE TRUST'S ABILITY TO OPERATE AND REPORT, DUE TO SOFTWARE CODING ERRORS AND/OR CHANGED FEATURES THAT ARE INCOMPATIBLE WITH THE WAY THE SYSTEM IS USED IN THE TRUST | • Depending on the system and the issues there is the potential for:<br>Clinical impact<br>Financial impact<br>Quality & performance impact<br>Reputation impact | • Software is tested by IPHIS and/or service departments prior to implementation.<br>• Industry standard (ITIL) change management processes are followed and documented for all changes to systems, including software upgrades.<br>• Major IT systems identified<br>• Test environments for PAS system complete<br>• Documented process for testing new and upgraded software: PAS complete | 9<br>3x3 | 9<br>3x3 | 9<br>3x3 | • Ensure test environments of those systems are adequate and can be populated with live data: to be completed by Mar 13<br>• Completed for PAS operational system, functionality cannot be tested without significant investment (c.£100k).<br>• Where no test environments exist it will not be possible to mitigate risk further without major investment.<br>• Agreed documented process for testing new and upgraded software for major IT systems: by Mar 13<br>• PAS operational system completed , Apex PIMS, PACS and ICE cannot be addressed currently.<br>• Graphnet EPR - this will only be upgraded if the Trust requests an upgrade, which is unlikely in the near future. Therefore this is not a priority at this time, but will be addressed before any planned upgrade<br>**TOLERATE** | • Record keeping of software upgrades of major IT systems, including user sign-off, incorporated into IPHIS standard change control processes | Feb 2014 | N/A | Chris Tite<br>**IGSG** |

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| 1.32<br>1<br>(1.1) | C, F, Q&P, SD, R – Assessment | Jun 2012 | REQUIREMENT TO BALANCE DATA PROTECTION AND CLINICAL RISK FACTORS FROM ADHERENCE TO THE SAFE HAVEN POLICY (FAXING CONFIDENTIAL INFORMATION) | Information Risks:<br>• Breach of confidentiality (unauthorised disclosure)<br>• Damage / distress to individuals affected<br>• Potential legal action against Trust<br>• Damage to Trust reputation<br>• Loss of confidence in Trust services<br>• Potential regulatory action including financial penalties (up to £500k)<br>Clinical Risks<br>• Failure to communicate urgent / important clinical information if can only send a fax when recipient has been contacted and confirmed they are ready to receive incoming information. | • Faxing Confidential Information best practice process<br>• Record of specialties confirming that faxing best practice guidance is displayed by every fax machine – all areas have confirmed except for Surgery and Cancer CSC<br>• Promotion of alternative arrangements for sending confidential information<br>• Minor deviation from policy has risk managed (for one example)<br>• Safe Haven Policy has been reviewed – discourages use of fax transmissions and acknowledges the potential for adverse risks from strict adherence<br>• All discharges are scanned to community midwives using NHS.net accounts | 15<br>5x3 | 8<br>4x2 | 4<br>4x1 | • Electronic Discharge Summaries will reduce use of fax<br>• GP's IT lead and Trust IT lead to confirm which practices are happy to receive communications by e-mail rather than fax<br>• Two possible IT projects for 2013/14 that could help reduce use of fax transmissions (but projects have not been confirmed)<br>• Once directory of GP email addresses is finalised Maternity will send all discharges electronically | • Monitored at IGSG<br>• Incident analysis<br>• Flow Mapping Registers identify risks associated with individual transfers of PID<br>• Assessment of change in volume / frequency of fax use – and why | Dec 2013 | Mar 2014 | James Taylor<br>**IGSG** |

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| 1.33<br>4<br>(1.2) | SD / R / C / Q&P – Assessment | Sep 2011 | MISIDENTIFICATION OF BLOOD SAMPLES SENT TO THE LABORATORY INDICATING PATIENT WAS NOT IDENTIFIED AT THE BEDSIDE | • Patient safety – particularly in transfusion patients where potential for serious consequences<br>• Potential for litigation and damage to Trust Reputation | • Trust Phlebotomy policy<br>• Phlebotomy training<br>• Laboratory professionals question any anomalous results and request repeat samples where appropriate | 12<br>4x3 | 8<br>4x2 | 4<br>4x1 | • Continue constant monitoring and vigilance by laboratory staff.<br>• Increased awareness within Trust<br>• Regular reporting to CSC's to restart<br>• Amber style panels to be held to determine cause and action plan foe incidents to begin May 13<br>• Number of incidents have reduced by almost 50% based on Aprils figures.<br>• Phlebotomy is a key area for training to reduce even further<br>• Risk rating reduced<br>• Amber panels to continue<br><br>Risk to be remain until Dec 2013 to confirm improvements continue | • Incident reporting and monitoring at CSC and Trust level<br>• Regular reporting at PSSG<br>• CSC reporting through Governance meetings<br>• Review of amber incidents and dissemination of learning | Dec<br>2013 | Dec<br>2013 | Steve Simpson<br>**CS Gov Committee** |

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| 1.34<br>4<br>(1.2) | C / Q&P / R - NPSA Alert | Oct 12 | NPSA ALERT DEMANDS THAT ALL SPINAL DEVICES ARE NON-LUER BY APRIL 1ST 2012. THIS IS TO REDUCE RISK OF ACCIDENTAL MISCONNECTION WITH OTHER, IE INTRAVENOUS DEVICES.<br>NONLUER DEVICES DID NOT EXIST AT THE TIME OF THE ALERT. | • Non-Compliance with NPSA Alert<br>• Patient Safety | • Evaluation of all manufacturers who supply devices has identified three favoured suppliers<br>• Decision made to avoid additional risk to patients by not having a mixed stock of Luer and Non-Luer spinal devices within the Trust, or employing an inferior quality device.<br>• Oncology review assessed practice as exemplary in the safe delivery of chemotherapy | 9<br>3x3 | 9<br>3x3 | 3<br>3x1 | • Interim decision to continue to use the Luer devices which we have always used until the favored companies can assure us that they can provide the full range of devices, allowing a complete move across to Non-Luer.<br>• ISO have determined that an international standard for non luer connectors be introduced by 2015. Therefore manufacturers are ceasing production of non luer connectors until clarification of requirements by ISO | • n/a | Jun<br>2014 | Jun<br>2015 | Sean Elliot<br>**MDMC** |

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| 1.38<br>4<br>(1.2) | C E H&S O&P R SD / Incidents | April 13 | RISK OF PATIENT INJURY FOLLOWING INPATIENT FALLS DUE TO FAILURE TO FOLLOW POLICY. THIS INCLUDES:<br>• Appropriate risk assessment and care planning.<br>• Responding in an appropriate and timely way when the risk changes<br>• Post fall responses including clinical monitoring and care planning<br>Update<br>• Cluster of injurious falls in Medicine CSC | • Patient safety<br>• Organisational reputation – links to Coroner's inquest findings<br>Update<br>• Significant patient injury | • Falls Policy<br>• Bedrail Policy<br>• Falls link champions<br>• Falls Prevention Group<br>• Falls CNS in post – will be vacant as of 24.01.14<br>• Excellent links with CSC – based Practice educators<br>• Falls assessment in nursing admission document.<br>• Falls Safe Bundle – completed in 50% inpatient areas – now extending into remainder of hospital<br>• Comprehensive Falls training/ essential skills/ induction and patient safety for RNs<br>• Staff training via HCSW trust training schedule<br>• Specific ward targeted training for RN's on post fall procedures - use of flat lifting equipment and neurological observations<br>• M&M meeting presentations to encourage engagement of medical staff.<br>• Individual CSC Governance presentations.<br>• Individual and time limited targeted action plans with wards<br>Update<br>• Focused staff training at all levels<br>• Individual learning needs identified and met<br>• Case based learning events<br>• Practical clinical skills sessions in progress | 12<br>4x3 | 12<br>4x3 | 8<br>4x2 | • Further Improvements to nursing documentation Falls assessment not consistent in all nursing admission documents for elective surgical procedures (inc electronic version) and day cases or ICP documents – ongoing<br>• Simulation training scenario being worked up inputted by MOPRS to raise awareness of need for comprehensive assessment and management of patients at risk of falls among medical staff.<br>• Introduction of e-learning module into essential skills framework, and increase attendance and completion of training – ongoing discussions with Learning & Development<br>Update<br>• Bid accepted to secure funding to extend FallSafe team. Work commenced Oct 13. Band 5 still under negotiation with MOPRS<br>• Ongoing issues with e-learning on ESR database not updating individual staff profiles. | • Monitored by Falls Prevention Group<br>• Reporting/ monitoring by Patient Safety Steering Group | Dec<br>2013 | Mar<br>2014 | Julie Windsor<br>**PSSG** |

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| 1.40<br>26<br>(1.2) | C, Q&P, R | June 2013 | FAILURE TO ACHIEVE INTERNAL AND EXTERNAL SET QUALITY REQUIREMENTS<br>High risk areas include<br>• Rule 43 letter relating to falls - Q2 increase in injurious falls in Medicine<br>• Grade 3 and 4 pressure ulcers - (avoidable) over trajectory at Q2<br>• Dementia screening - has only achieved 1 month (September) of target of 90%<br>• Rising C – Dif numbers at trajectory for Q2. See risk 1.13 | • Reputational damage<br>• Potential fines<br>• Patient safety | • Governance framework and monitoring – Quality Improvement framework<br>• Performance and kit bag metrics<br>• Monitor compliance framework<br>• CSC Performance Reviews<br>• Gov and Quality Committee and reporting timetable<br>• Patient Safety Steering Group and associated workstreams<br>• Clinical effectiveness Steering Group<br>• Patient Experience steering Group<br>• CQRM and quality contract reporting<br>• Monthly and quarterly reporting to the Board<br>• Monthly CQUIN meetings<br>• Identified leads for all quality contract indicators | 12<br>4x3 | 12<br>4x3 | 8<br>4x2 | • Monthly monitoring of KPIs with HoN<br>• Daily dementia screening meetings to improve compliance<br>• Recovery plan for reducing pressure ulcers – roll out of enhanced Braden with acute triggers, implementation of the SKIn bundle, and introduction of weekly audit<br>• Turnaround programme for reduction of falls and implementation of falls safe programme across Medicine CSC<br>• Implementation of Vital Pac module for dementia screening Oct/Nov 13<br>• Implementation of Infection Control action plan – see risk 1.13 | • Gov and Quality Committee<br>• Patient Safety Steering Group<br>• Clinical effectiveness Steering Group<br>• Patient Experience steering Group<br>• CQRM and quality contract reporting | Dec 13 | Apr 2014 | L Wilkinson<br>**G & Q** |

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| 1.41<br>4<br>(1.2, 1.3, 1.4, 1.51.6, 1.7,) | C, F, R, Q&P/ Assessment | June 2013 | UNINTENDED CONSEQUENCES TO DELIVERY AND QUALITY OF CARE DUE TO COST IMPROVEMENT PROGRAMME | • Reputational damage<br>• Patient safety compromised<br>• Poor patient experience<br>• Poor staff experience and engagement<br>• Clinical outcomes | • QIA process and associated policy<br>• QIA metrics and tracker system hosted by PMO<br>• MD/DN sign off of any QIAs<br>• Performance monitoring framework<br>• Trust performance and kit bag metrics<br>• Governance structures<br>• CSC level performance reviews | 12<br>4x3 | 12<br>4x3 | 8<br>4x2 | • Monthly meetings with DoN and MD to sign off and discuss any QIAs<br>• Embed Board assurance reporting for this process<br>• Budget rebalancing to be finalized<br>• CSCs to report CIP impact and progress as part of regular quality reporting template to Governance and Quality Committee<br>• CSC governance meetings to provide assurance around how CIP programmes being monitored for quality impact | • Governence and Quality Committee<br>• SMT<br>• Trust Board<br>• Financial recovery Group | Dec<br>2013 | Apr<br>2014 | LWilkinson/D Burroughs<br>**G&Q** |

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| 1.42<br>4,13<br>(1.4, 4.1) | C, H&S, L, Q&P,R, SD | | CONCERNS WITH HEALTH RECORDS FUNCTION<br>▪ Insufficient staff within culling team.<br>▪ Lack of roller racking in medical records will mean that PHT will run out of storage space<br>▪ The roof at the main record is prone to leaking which could cause damage to records | • Unwieldy notes that present a clinical risk<br>• Unable to store records to accepted standard and increasing clinical risk associated<br>• Large volumes of patient records are not marrying up with the main patient record and are being stored outside the record library(not fully aware of full extent of this problem<br>• Unable to obtain NHSLA level 2 due to current storage arrangements in Ophthalmology<br>• Clinical risk due to patient records not being held with the main record<br>• H&S and Clinical risk due to leaking roof | • Business case submitted for roller racking and repair to roof – awaiting go ahead<br>• Good standards and controls for management of patient health records in the main library<br>• Some culling is being performed<br>• IGSG does monitor some of the issues raised | 15<br>3x5 | 12<br>3x4 | 6<br>3x2 | • Re-submission of business case for roller racking and roof repair<br>• Rescope requirement for culling function at PHT and draw up an associated plan/business case.<br>• Fully scope the problem of notes being maintained separately to the main health record and being stored outside the main record library, and develop an associated plan and business case.<br>• Finance agreed for roller racking<br>• Re-scoping of culling function achieved – with new ways of working<br>• Sate of Ophthalmic notes considerably improved<br>• Review of all notes storage completed, plan has been written | • Monitor through RAC<br>• Monitor through IGSG<br>• Monitor through CS CSC Governance meetings | Dec<br>2013 | Nov<br>2014 | Alison Fitzsimons<br>**IGSG** |

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| 1.43<br>10<br>(1.2) | F / H&S / R / SD / -Risk Assessment | Jan 12 | BLOCKAGE OF SEWAGE SERVICES LEADING TO FLOODING WITHIN DEPARTMENTS, PREDOMINANTLY PAEDIATRICS | • Ward Evacuation<br>• Cancellation of elective activity<br>• Infection hazard<br>• Replacement of contaminated equipment<br>• Trust reputation | • Initial survey resulting in drain repairs, drain realignment and flushing where required.<br>• Identified defects repaired<br>• Completed 2012 drains survey<br>• Flow tests undertaken: inappropriate items being disposed of through system: hand towels / pt wipes | 9<br>3x3 | 9<br>3x3 | 6<br>3x2 | • CSL to educate all users to avoid overloading<br>• CSL to devise escalation processes<br>• If survey identifies defects, Implement further remedial works programme<br>• Investigate possibility of purchasing 'flushable' pt wipes<br>• Investigate re-introduction of small 'bags' for disposal of pt-related towels etc<br>• DoN to discuss with Pt Environment Group<br>• Sewage leaks ongoing mainly due to wrong disposal<br>• CSL and PHT are to undertake further presentations to colleagues highlighting the cost and impact of incorrect disposal of products down the drain<br>Update<br>• Degradable disposable wipes - trial commenced in New Build areas only on 8th November 2013. Need time to assess and assure that the introduction of them would help solve the problem | • Incident reporting | Jan 2014 | Review Jan 2014 | J A'Court<br>CCRG |

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| 1.44<br>4<br>(1.6) | C/F/Q&P/R/SD – Risk Assessment | Oct 12 | THE TRUST FAILS TO ACHIEVE KEY LOCAL AND NATIONAL ACCESS STANDARDS AND TARGETS. | • Patient experience<br>• Patient safety<br>• Quality/clinical outcomes<br>• Trust financial position<br>• Trust reputation | • CSC performance reviews<br>• Trust-wide performance assurance processes<br>• Day to day operational management<br>• Performance recovery plans where required<br>• Joint pathway reviews with CCGs<br>**RTT**<br>Update<br>• Waiting list assurance meeting<br>• Additional operational recovery group meeting to track progress against the Board approve plan<br>• Specialty level sustainability plans<br>**Cancer**<br>• Cancer operational meeting weekly<br>• Monthly cancer steering group<br>• New Cancer reporting tool<br>• Cancer access policy training completed<br>Update<br>• Cancer improvement plan completed<br>• New 'forward look' reports to identify patients near breach date or booked post breach date<br>• Bi-weekly meetings with COO | **16**<br>**4x4** | **16**<br>**4x4** | **9**<br>**3x3** | • Approved recovery plans to be implemented<br>**RTT**<br>• Implement existing recovery and new non-admitted recovery plan<br>**Cancer**<br>• Complete treatment plan for outstanding breached patients<br>Update<br>• Deep dive and milestone plans commenced to reduce 2 week wait to 1 week wait for all patients in all specialties<br>**Stroke**<br>• Continuous improvement processes implemented by service<br>• Direct admissions YTD 90.9% | • Integrated Performance Report<br>• CSC performance reports<br>• CSC performance reviews<br>**RTT/Cancer/ Diagnostic Waits**<br>• Trust Waiting List Assurance meeting<br>Update<br>• Back log reduction for waiting list patients<br>• Weekly monitoring of forecast performance<br>**StrokeService**<br>• Operational and strategy assurance meetings | Dec<br>2013 | Apr<br>2014 | M Morgan<br>**SMT** |

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| 1.45<br>4<br>1.6 | C,F,O&P,R, SD, I | Dec 12 | LACK OF INTERNAL CAPACITY TO MAINTAIN ACCEPTABLE CLINICAL FOLLOW UP WAITING TIMES ACROSS OPHTHALMOLOGY AND EAR , NOSE AND THROAT<br><br>BACK LOG OF PATIENTS WAITING FOR FOLLOW UP<br><br>LACK OF COMMISSIONER ENGAGEMENT TO ASSIST MANAGEMENT OF SITUATION (EYES)<br><br>LACK OF COMMUNITY CAPACITY IN WHICH TO DISCHARGE STABLE PATIENTS | • Increased risk of blindness<br>• Irreversible damage to eyesight<br>• Malignancy and potential for inoperable spread from lesions and tumors<br>• Potential to fail the delivery of sustained waiting time and RTT<br>• Possible to litigation due to delays resulting in deterioration of condition.<br>• Financial impact of the need for extra clinics | • Risk originally opened in 2009. It has been regularly reviewed<br>• Continues on of the CSC top 5 risks reported via governance<br>• Management of the OWL at weekly CSC waiting list PTL meetings<br>• Regular discussions with the Consultant teams regarding removal of the OWL and strategies to manage it<br>• Clinical and non-clinical validation of OWL<br>• Ensuring all clinics fully utilised | 25<br>5x5 | 20<br>5x4 | 10<br>5x2 | • Monitoring patient concerns regarding delays<br>• Continued clinician engagement to assess on a patient by patient basis<br>• Engagement with commissioners re demand management<br>• Workforce review to ensure demand and capacity become matched and to prevent future occurrence<br>• Additional capacity being provided through CESP clinics<br>• Patients being risk assessed through new clinical score to prioritise order of booking | • Auditing of appropriateness of follow up appointments<br>• Management of OWL at weekly CSC waiting list PTL meetings<br>• Complaint monitoring | Dec 2013 | Apr 2014 | N Martin<br>**SMT** |

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| 1.46<br>4<br>(1.5) | SD / R / C / Q&P – Assessment | May 2010 | REPEADTED AND PROLONGED OVERCROWDING WITHIN ED RESULTS IN POOR PATIENT EXPERIENCE COMPROMISED SAFETY AND IMPACTS ON STAFF WELLBEING<br>. | • Clinical safety of patients<br>• Reputation of Trust compromised<br>• Patients not having initial assessments within 15 minutes and not seeing doctor within one hour of arrival.<br>• Financial penalties linked to ambulance handover times and non - achievement of 4 hour target<br>• Poor privacy, dignity and overall patient experience as little or no facilities available in ED corridor,<br>• Unsuitable environment for patients<br>• Staff stress<br>• Potential for increased errors<br>• Inability to achieve Emergency care quality standards | • Weekly discharge improvement meetings in place to improve quality and speed of discharges<br>• Daily review of breaches and 2 hourly escalation to COO<br>• OOHS Direct referral from ED and Gosport minor injuries unit.<br>• Deputy DHMs now in post supporting OOHs<br>• .<br>• ED consultants present until midnight 7 days<br>• Extra consultant shift on Saturday and Sunday<br>• Newly qualified nurses start Oct will bring staff to establishment<br>• Trust wide recovery plan approved and in place<br>• Mitigation plan<br>Update<br>• Newly qualified nurses commenced<br>• GPs in ED Friday - Monday<br>• Positive reinforcement that best practice is to reduce rather than manage queue<br>• Ambulatory pathways extended and care spaces increased to 15 | 25<br>5x5 | 15<br>5x3 | 15<br>5x3 | • Trust recovery plan to be fully implemented | • Trust KPIs<br>• Daily Operational Performance Meetings<br>• Weekly Trust Recovery Group<br>• SMT<br>• Plan monitored weekly by Deputy COO and monthly by TDA<br>• Trust Board | Dec 2013 | End Nov 2013 | Maria Purse/Isabel Gaylard<br>**SMT** |

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| 1.47<br>4<br>(1.6) | C/Q&P/SD | April 2013 | DIMINISHED ORTHOTIC SUPPORT HAS LED TO DELAY IN PATIENTS BEING ABLE TO ACCESS THE SERVICE FOR NEW REFERRALS, FOLLOW UP AND REVIEW IN ORTHOPAEDIC CLINICS AND MOPRS.<br>. | • Delays in reviewing pts. Potentially having a negative clinical implication<br>• Risk of poorly fitting and or incorrect orthotics being used<br>• Less than optimal outcome for some complex patients, including babies who attend the clicky hip clinic<br>• Poor patient experience<br>• Potential loss of reputation to the trust<br>• In patients may have a delayed discharge and potentially reduce their outcomes. May also put them at risk of hospital acquired complications. | • Fracture clinic staff have/are in the process of being trained in basic orthotics commonly used in MSK, to reduce the level of non-essential referrals and maxims use of recourses.<br>• Admin presence has been sustained daily in the Orthotic service to receive referrals from the wards and replenish stock<br>• Otto Bott have put in place a management plan to manage the back log. This also includes a plan to develop pathways and procedures to ensure effective process are in place<br>Update<br>• Operational project lead<br>• Training performance plan ongoing | 20<br>4x5 | 16<br>4x4 | 8<br>4x2 | • Initial scoping exercise will determine new ways of working<br>• Otto Bott have been contracted to provide a service to address the back log<br>• Improved SOPs and referral process<br>• Partnership working with specialties<br>• Greater availability of core stock /consignment stock at specialty level<br>• Changes to pathways to ensure seamless process<br>• Internal communication to surgeons and orthopedics under way<br>• Update provided to the commissioners who were satisfied with our progress and would like a final update in January<br>Update<br>• Improvement in backlog, all urgent patients have been reviewed and waiting list has reduced from aprox 1000 to 300<br>• Improved picture for MOPRS patients on backlog no patient waiting more than 12 weeks but still high risk in Orthopaedics as no Orthotist link with MOPRS. Ongoing implementation of action plan should result in risk score reduction in December | • Patient Outcome including discharge data, patient waiting times reduced outcomes<br>• Internal recovery plan in place with milestones – progress meetings in place<br>• MOPRS Governance meetings<br>• Through RAC | Dec<br>2013 | Jan<br>2014 | Hayley Wagner / Mike Quinn<br>**MOPRS Governance/RAC** |

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| 1.48<br>16<br>(1.1, 1.2, 1.4, 1.6, 1.7) | C/F/Q&P/SD Audit / Incident | Jul 2013 | QUALITY OF DATA PRODUCED AND PROVIDED FOR USE IN INTERNAL PERFORMANCE REPORTING AND FOR EXTERNAL REPORTING IS INACCURATE | • Trust reputation is undermined<br>• Financial penalties associated with loss of CQUIN or fines due to contract requirements, impacts on overall Trust financial position<br>• Incorrect data affects decisions for operational management and business planning<br>• Patient safety | • Data validation processes in place in some areas but patchy<br>• Data Quality Working Group established<br>• Data Quality Strategy outline devised and agreed | 16<br>4x4 | 16<br>4x4 | 8<br>4x2 | • Implement Data Quality Strategy<br>• Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust<br>• Complete actions detailed in Deloitte Internal Audit<br>• Complete recommendations resulting from Serious Incident investigation | • Data validation exercises<br>• Regular reporting to Audit Committee | Dec 2013 | Apr 2014 | Peter Mellor<br>**Audit Committee** |

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| 1.49<br>4<br>(1.2) | C/Q&P/SD - Assessment | August 2013 | AT TIMES OF HIGH CAPACITY DECISIONS ARE MADE TO MOVE PATIENTS OUT OF THEIR SPECIALTY FOOT PRINT FOR THE PROVISION OF THEIR CARE. | • Patient safety is potentially compromised as a result of care on non-specialist outlier ward<br>• Dilution of specialty clinical staff (outliers<br>• Increased likelihood of delay in patient journey<br>• Difficulty in identifying suitable patients can result in complex patients being moved thereby increasing the risk | • Daily list of patients that are outlied is produced and medical team review on a daily basis<br>• Clinical staff undertake individual decision making process for each patient moved | 16<br>4x3 | 16<br>4x3 | 8<br>4x2 | • Outlying policy currently under review needs completing and implementing<br>• Early bird discharge work with targets set for each CSC and daily performance meeting in place to drive improvements<br>• Hospital work in place to increased efficiencies in patient pathway through CQUIN work and Newton<br>• Early Bird Discharge (IDB) work continuing – targets have been set for all CSCs, performance against targets are reported daily via KitBag. In reach team introduced Oct 2013<br>• Funding for outlier teams for Medicine and MOPRS requested as part of NHS England A & E Recovery Improvement plan – team recruited to support MOPRS as part of 2012/13 winter pressures and funding extended to Jul 2013, MOPRS now funding as cost pressure. | • Through CSC governance monthly reviews<br>• IDB Meetings twice a week, time moved to 11 am action s chased up at 14.30 conference call ensuring accountability.<br>• Monitoring IDB performance on weekly basic as part of Trust Recovery Group<br>• For the first time as of 29 Oct combined Medicine and MOPRS outliers reduced to 10 with the plan for all medical and MOPRS outliers to cease as part of the overall LoS reduction and bed management initiatives. | Dec<br>2013 | Apr<br>2014 | Gill Parker<br>**SMT** |

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| 1.50<br>4<br>(1.9) | C/Q&P/SD - Assessment | | LACK OF EQUIVALENT WORKFORCE ACROSS SEVEN DAYS OF THE WEEK | • Reduced quality of care<br>• Damage to Trust reputation<br>• Poor patient experience | • Governance systems in place to ensure patient safety and quality of care is maintained<br>• Weekend HSMR shows no significant difference to comparable Trusts<br>• Weekend HSMR shows no significant difference from rates recorded during the week | 12<br>4x3 | 12<br>4x3 | 8<br>4x2 | Update<br>• Mortality review Toolkit will become available soon which will allow monitoring of week end mortality | • Review of hospital mortality with emphasis on weekend mortality with TDA | Review plan<br>Jan<br>2014 | | S Holmes<br>**SMT** |
| 1.51<br>4<br>(1.7) | C/Q&P/SD - Assessment | | TRUST FAILS TO ACHIEVE CANCER WAIT TARGETS | • Clinical outcomes<br>• Patients are not seen in a timely manner<br>• Financial penalties may be applied by commissioners | • Capacity and demand modelling undertaken and in place within CSCs<br>• Weekly assurance meeting with forecast planning and triggers for escalation<br>• Daily PTL meetings within CSCs to track progress of patients on cancer pathway<br>• Roll out for Cancer Access policy training on track<br>• Weekly cancer operational meeting established<br>Update<br>• Cancer improvement plan completed<br>• New 'forward look' reports to identify patients near breach date or booked post breach date<br>• Bi-weekly meetings with COO | 20<br>5x4 | 16<br>4x4 | 8<br>4x2 | • Agreed to establish internal cancer improvement plan to include the areas of poor performance (bottom 20% of Trusts) from cancer survey<br>Update<br>• Deep dive and milestone plans commenced to reduce 2 week wait to 1 week wait for all patients in all specialties<br>• Colorectal service review underway | • Weekly cancer operational meeting<br>• Monthly updates to RAP diarised with assigned manager | Dec<br>2013 | Apr<br>2014 | M Morgan<br>**SMT** |

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| 1.52<br>4, 26 | Risk Assessment | Oct 2014 | IMPLEMENTATION OF THE TRUST'S BED REDUCTION PLAN | • Increased concentration of acuity on wards<br>• Possibility of unaligned skill mix in these areas<br>• Potential for increased patient safety incidents if discharge is expedited inappropriately<br>• Potential for insufficient winter step up capacity | • Monitoring of KPIs on a weekly basis to include:<br>• Complaints<br>• Re-admission<br>• Length of Stay(LoS)<br>• Weekly review of bed capacity against activity | 16<br>4x4 | 16<br>4x4 | 8<br>4x2 | • Closure plan to be finalised and agreed<br>• Implement agreed plan<br>• Undertake any required skill mix vs acuity review using Trust approved tool<br>• Implement early discharge plan<br>• Ensure effective communication with patient throughout their stay | • KPIs monitored weekly by LoS steering group<br>• Monthly reporting to project steering group chaired by Executive | Jan 2014 | Apr 2014 | J Dawes<br>**SMT** |
| 3.1<br>4<br>(1.2) | C/F/Q&P/R/SD – Assessment | Aug 2011 | THE TRUST REQUIREMENT TO USE VITALPAC TO GENERATE AN ELECTRONIC DISCHARGE SUMMARY FOR ALL PATIENTS IS EXPERIENCING DELAYS IN IMPLEMENTATION | • Loss of Trust Reputation<br>• Damaged Relationships with commissioning GPs<br>• Sub optimal patient pathway and patient safety<br>• Failure to comply with contract<br>• Inconsistent use of EDS across specialties<br>• Potential delay in information transfer to GPs | • All GP surgeries in Portsmouth, IOW and a selection of Hampshire configured to receive EDS by NHS Mail<br>• Trust EDS solution rolled out across all unscheduled care areas<br>• Roll out of iDesktop underway<br>• Action plan for achieving improved completion rates shared with commissioners | 9<br>3x3 | 9<br>3x3 | 6<br>3x2 | • IT to investigate ways to shorten the time taken to issue an electronic discharge summary<br>• Trust now developing ''EDS Light'', to be agreed with Clinicians and Commissioners, and implemented as mandatory requirement.<br>• iDesktop to be fully rolled out across Trust<br>• On confirmation of complete directory of GP electronic addresses, maternity will submit all discharges electronically<br>• Ongoing discussions with senior clinicians to ensure engagement and drive increased usage in medical staff | • Monitored at monthly commissioning meeting<br>• Monitored by Performance Tool at CSC level<br>• Monitored at Audit Committee and RAC | Dec 2013 | Apr 2014 | C Tite<br>**RAC** |

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| 4.1<br>3<br>(4.3) | C / H & S / R / SD – Assessment | Dec 2009 | THE NHSP/AGENCY FILL RATE HAS REMAINED AT 75 - 80 %<br>THE GAP IS REGISTERED NURSES<br>THIS RESULTING GAP, CAN BE CRITICAL WITHIN SOME HIGH DEMAND AND ACUITY AREAS – ED, ACUTE WARDS.<br>LARGE NUMBERS OF NEW STARTERS WILL HAVE COMMENCED BY END OCT 2013, HOWEVER SIGNIFICANT GAPS IN RNs REMAIN WITHIN MEDICINE AND MOPRS<br>AGGRESSIVE RECRUITMENT CONTINUES | • Quality and safety of patient care.<br>• Clinical wards are staffed with a lower level of permanent staff, impacting on quality of care | • Continued monthly panels (WSC) established to consider requests for new or replacement staff.<br>• Provision of Senior Nurse/Matron cover over 24 hour period to ensure patient care and escalation process to request temporary staffing from NHSP and other agencies<br>• Re-allocation to wards of other clinical staff from non ward based nursing duties<br>• Partner organisations work with PHT to reduce extra capacity<br>• Non Framework agencies now removed from agency cascade, exception requiring Executive approval<br>• Ward based staffing review complete<br>• Bed reduction plan in progress<br>• Ongoing recruitment for band 2 and band 5<br>• Further NHSP and Trust recruitment for band 5s from the EU | 20<br>4X5 | 9<br>3x3 | 9<br>3x3 | • All band 5 and band 2 ward based posts bypass WSC once approved within CSC<br>• HR lead project initiated to recruit to establishment<br>• Additional staffing assessments initiated as required to resolve immediate problems<br>• Other permanent PHT staff support clinical ward teams where feasible/practical<br>• Continued recruitment to identified and agreed vacancies overseen by lead nurse for workforce<br>• Recruit to identified and agreed vacancies overseen by lead nurse for workforce<br>• 2013/2014 Recruitment plan in place incorporating on going 2 weekly adverts (vacancies reduced due to recent recruitment)<br>• Further overseas (EU)<br>• RN recruitment with NHSP to cover the increasing vacancies over the summer period. | • Daily senior nurse monitoring meetings<br>• Operations report x 3 daily<br>• Daily written report from staffing and duty matron detailing actions to ensure safe care<br>• Weekly monitoring of recruitment by Lead Nurse for Workforce.<br>• Weekly staffing planning meeting<br>• Weekly monitoring of current staff in post, temp use and number of extra beds<br>• Weekly monitoring of agency cascade and impact of changes<br>• Weekly monitoring of temp staffing utilisation | Jan<br>2014 | Review<br>Jan<br>2014 | N Lucey<br>NW/HR RC |

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| 4.2<br>13<br>(4.1) | C/H&S/L/Q&P/R/SD – Internal Audit Report | Oct 2012 | COMPLETION OF STAFF APPRAISALS FALLS BELOW THE LEVEL ACCEPTABLE TO THE TRUST BOARD – 85% | • Staff are not performance managed effectively<br>• There is no review of individual development needs. | • Compliance is monitored through the monthly performance review meetings with each CSC.<br>• Compliance is reported to the Trust Board monthly. | 12<br>3x4 | 9<br>3x3 | 6<br>3x2 | • Director of Workforce and OD letter to CSC Management team with individual names of non-compliance. Failure to achieve compliance will result in performance management measures being undertaken against the manager and employee, this may include stopping incremental progression<br>Update<br>• Currently Trust 82% compliant, ED Medicine and MSK are reporting weekly on compliance achievement | ▪ Monthly performance review meeting process with CSC's. | Dec 2013 | Mar 2014 | R Kopecek<br>**SEC** |

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| 4.3<br>13<br>(4.1) | C/H&S/L/Q&P/R/SD – Assessment | Jul 2013 | STAFF SURVEY RESULTS DO NOT IMPROVE SUFFICIENTLY TO INDICATE ENGAGEMENT OF WORKFORCE AND IMPROVE POSITION OF TRUST'S SCORES NATIONALLY | • Suboptimal patient care<br>• Lack of understanding/buy in, leads to non - delivery of strategic priorities<br>• Reduced productivity and inefficiencies across areas of the workforce.<br>• Potential loss of CQUIN | • Listening into Action programme<br>• Staff survey action plans developed within CSCs<br>• Health and well-being programme established.<br>• Employee recognition programmes in place.<br>• Appraisal and performance management process<br>• Improved performance in 2012 national staff survey results<br>• Working Together For Patients (WT4P) programme | 12<br>3x4 | 12<br>3x4 | 6<br>3x2 | • Quick wins identified through Listening into Action programme combined with enabling projects and first 10 pioneer teams.<br>• Re-energise quarterly staff pulse survey to include questions consistent with National Staff Survey.<br>• Extend National Staff Survey coverage to include wider number of Trust employees including staff employed by Carillion.<br>Update<br>• Q2 Pulse Survey results slightly deteriorated | • Integrated performance report to Board including staff feedback<br>• Results of Pulse Survey | Jan 2014 | Apr 2014 | T Powell<br>**SEC** |

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| 4.4<br>13<br>(4.2) | | | CAPACITY AND CAPABILITY GAPS IN KEY MANAGEMENT POSITIONS BOTH OPERATIONAL AND CLINICAL WITHIN THE TRUST | • Non delivery of key operational targets<br>• Non delivery of key financial targets<br>• Non delivery of key quality targets<br>• Poor levels of employee engagement | • Performance assurance framework and performance review process<br>• Trust Recovery Group action plan | 16<br>4x4 | 12<br>4x3 | 8<br>4x2 | ▪ Implement an operational management training scheme aimed at individuals who have aspiration and aptitude to undertake key roles in the future<br>▪ Introduce robust process for succession planning to critical senior management posts<br>▪ All Managing Director, General Manager and Operational Manager posts to be substantively filled<br>▪ Complete CSC cluster structure including the scope of the Managing Director posts<br>▪ Restructure of Medical leadership to be undertaken to include appointments to Associate Medical Director and Clinical Director posts | ▪ NTDA self certification process<br>▪ Leadership Academy programme development<br>▪ Listening into Action master class outputs | Jan<br>2014 | Mar<br>2015 | T Powell<br>**SMT** |
| 4.5<br>13<br>(4.1) | | | COMPLETION OF ESSENTIAL SKILLS TRAINING FALLS BELOW THE LEVEL ACCEPTABLE TO THE TRUST BOARD – 85%<br>WITH<br>INFORMATION GOVERNANCE REQUIRING 95% | • Basic training that is deemed essential is not completed leading to clinical risk.<br>• Information Governance at 81.2% and not the 95% required for the TDA by the end of October which is poor for the trust reputationally | • ESR support and training delivered by L&D team.<br>Update<br>• Trust have achieved three consecutive months over *%% compliance<br>. | 12<br>3x4 | 6<br>3x2 | 4<br>2x2 | • Ongoing monitoring to ensure continued compliance<br>Update<br>• Bespoke drop in sessions delivered to CSCs where Information Governance is below 95%<br>• Overall Trust compliance is at 93.3% | ▪ Monthly performance review meeting process with CSC's. | Jan<br>2014 | Mar<br>2014 | R Kopececk<br>**SEC** |

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| | | | | | | | | | | | **Review Date** | **Target Date** | |
| 5.1<br>26<br><br>(5.1, 5.2, 5.3, 5.4) | F / R – Assessment | Oct 2011 | THE TRUST IS UNABLE TO ACHIEVE ITS PLANNED YEAR END FINANCIAL POSITION 2013/14 | • Potential for TDA intervention<br>• Potential for liquidity (cash) problems<br>• Potential for measures being required that might risk posing a detrimental effect on services<br>• Reputational, perceived as a failing organization<br>• Jeopardise successful FT application | • **Monthly performance meetings:** with each corporate functions to review financial position in detail<br>• **Pay:** Controls include, budget monitoring and control, workforce strategy committee, temp staffing review meetings and Executive sign off for temporary posts.<br>• **Non Pay:** Controls include budget monitoring, agreed authorisation levels technical approvers for specific categories.<br>• **Income & Contract Penalties (inc CQUIN):** Controls include, contract monitoring reports and meetings, income assurance group with CSC's.<br>• Regular CQUIN meetings with CSCs to assess performance.<br>• **CIP programme:** Controls include monthly reports, Weekly Financial Recovery Group.<br>• **CSC/Corporate Functions:** Controls include budget monitoring and monthly performance reviews with Exec team<br>• New performance review meetings now in place utilizing bottom up forecasts signed off by CSC management<br>• KitBag reporting of key metrics fully implemented | 12<br>4x3 | 16<br>4x4 | 12<br>4x3 | • Trust Recovery Plan established targeting £4m of cost reductions to Trust Run rate<br>Update<br>• Current position remains the same | • Monthly reporting to all relevant meetings (EMT, SMT, Finance Committee & Trust Board)<br>• Trust Recovery Group established chaired by Deputy Chief Executive | Jan<br>2014 | Apr<br>2014 | Brian Maxton<br>**FC** |

| ID / CQC Ref / (AF Ref) | TYPE / SOURCE | DATE OPENED | RISK DESCRIPTION | IMPACT | ACTIVE CONTROLS ALREADY IN PLACE | INITIAL RISK RATING (C X L) | CURRENT RISK RATING (C X L) | PREDICTED RESIDUAL RISK RATING (C x L) | ACTION PLAN TO ACHIEVE PREDICTED (RESIDUAL) RISK RATING | ASSURANCE MECHANISM / MONITORING | Review Date<br>On target / Minor obstacle to achieving target / Inability to achieve predicted target<br>Review Date | Final target date for mitigation of risk<br>RAG rated for progress<br>Target Date | RESPONSIBLE LEAD / COMMITTEE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.2<br>26<br>(5.1, 5.2, 5.3, 5.4) | F / R – Assessment | July 2013 | • THE TRUST IS UNABLE TO MAINTAIN SUFFICIENT LIQUIDITY/CASH | • Potential for TDA intervention.<br>• Potential for measures being required that might have a detrimental effect on services.<br>• Reputational, perceived as failing organisation.<br>• Insufficient liquidity would prevent successful FT application. | • Daily updates to actual cash flow and monthly update to forecast.<br>• Regular reporting to Finance Committee and Board, via Integrated Performance Report. | 12<br>4x3 | 12<br>(x3 | 9<br>3x3 | • Delivery of Trust financial plan (see 5.1 26)<br>• TDA assistance, by way of Revenue Support Loan.<br>• Potential for short term support via early payment by commissioners.<br>• Balance sheet management.<br>• Application for change to EFL to enable lower cash balance at year-end.<br>• Restriction on capital expenditure.<br>Update<br>• Current position remains the same | • Monthly reporting to Finance Committee and Trust Board.<br>• Monthly and Quarterly reporting to TDA. | Jan 2014 | Apr 2014 | Financial Controller<br>**Finance Committee** |

| LEADS | | | COMMITTEE/GROUP ABBREVIATIONS | | | OTHER ABBREVIATIONS | |
|---|---|---|---|---|---|---|---|
| JA | John A'Court | | CS Gov | Clinical Services Governance Committee | | CSC | Clinical Service Centre |
| SB | Sarah Balchin | | CCRG | Combined Contract Review Group | | CSL | Carillion Services Limited |
| SE | Sean Elliot | | G&Q | Governance & Quality Committee | | CQC | Care Quality Commission |
| AF | Alison Fitzsimmons | | FC | Finance Committee | | CRB | Criminal Records Bureau |
| IG | Isabel Gaylard | | F&S C | Fire and Safety Committee | | EDS | Electronic Discharge Summary |
| SH | Simon Holmes | | ICMC | Infection Control Management Committee | | HFRS | Hampshire Fire and Rescue Service |
| RK | Rebecca Kopecek | | IGSG | Information Governance Steering Group | | HII | High Impact Interventions |
| JL | Julia Lake | | ITSG | Information Technology Steering Group | | OBC | Outline Business Case |
| NL | Nicky Lucey | | MDMC | Medical Devices Management Committee | | PID | Person Identifiable Data |
| NM | Natasha Martin | | MHLG | Mental Health and Learning Disabilities Group | | NHSLA | National Health Service Litigation Authority |
| CM | Caroline Mitchell | | NW/HR RC | Nursing Workforce/ HR Risk Committee | | NHSP | National Health Service Professionals |
| TP | Tim Powell | | PEWG | Patient Experience Working Group | | | |
| SS | Steve Simpson | | PSWG | Patient Safety Working Group | | | |
| SSm | Steve Smith | | SC | Safeguarding Committee | | | |
| JS | Julie Sprack | | SMT | Senior Managers Team | | | |
| CT | Chris Tite | | WSC | Workforce Strategy Committee | | | |
| JT | James Taylor | | | | | | |
| CW | Cherry West | | | | | | |
| LW | Lorna WIlkinson | | | | | | |
| JW | Julie Windsor | | | | | | |
| | | | | | | | |

## Guidance for the Assessment of Risk Rating

| LIKELIHOOD (frequency) | | CONSEQUENCE (impact/severity) | | | | |
|---|---|---|---|---|---|---|
| | | Insignificant (1) | Minor (2) | Moderate (3) | Major (4) | Serious (5) |
| Rare | (1) | 1 | 2 | 3 | 4 | 5 |
| Unlikely | (2) | 2 | 4 | 6 | 8 | 10 |
| Possible | (3) | 3 | 6 | 9 | 12 | 15 |
| Likely | (4) | 4 | 8 | 12 | 16 | 20 |
| Highly likely | (5) | 5 | 10 | 15 | 20 | 25 |

| Colour | Risk |
|---|---|
| Green | Low Risk (1 – 3) |
| Yellow | Moderate Risk (4 – 6) |
| Amber | High Risk (8 – 12 ) |
| Red | Extreme Risk (15 – 25) |

| LIKELIHOOD | DESCRIPTOR | DESCRIPTION |
|---|---|---|
| 1 | Rare | Not expected to happen again except only in exceptional circumstances e.g. once a decade, or a probability of <1% |
| 2 | Unlikely | The event may re occur infrequently, but it is a possibility e.g. once a year or a probability of 1-5% |
| 3 | Possible | The event may re occur e.g. once a month, or a probability of 6-20% |
| 4 | Likely | The event will probably re occur e.g. weekly or a probability of 21-50% |
| 5 | Highly likely | The event is likely to re occur on many occasions, is a constant threat e.g. at least once a day or probability of >50%. More likely to occur than not. |

**GUIDANCE ON COMPLETION OF THE RISK REGISTER / RISK ASSESSMENT FORM**

| SECTION | COMMENTS |
|---|---|
| Ref No | • A number which allows the risk to be uniquely identified: this will inserted, once the risk is placed on the register |
| Type | • This is outlined on the top of the risk register and assessment form: a risk may be of more than one type |
| Date | • The date the risk was first placed onto the Register |
| Risk Description | • A statement that provides a brief, unambiguous and workable description, which enables the risk to be clearly understood, analysed and the requirement for additional controls identified |
| Impact | • This is the consequence should the risk be realised |
| Active Controls | • Details of any actual controls already in place i.e. factors that are exerting material influence over the risk's likelihood and impact: the risk rating.<br>• An effective control is one that is properly designed and delivers the intended objective / mitigates the risk |
| Initial Risk Rating | • The rating determined by likelihood x consequence using the 5 x 5 matrix<br>○ Likelihood: the likelihood of the risk happening - this score should take into account the existing controls<br>○ Consequence: the impact should the risk occur - this score should take into account the existing controls |
| Current Risk Rating | • This will initially be the same as the initial risk rating<br>• As time progresses, the current risk rating should decrease (if your controls are appropriate and effective) and move closer to the predicted residual risk rating |
| Further actions | • Further action(s) required to be taken in order to eliminate, mitigate or control the risk |
| Progress Update | • A brief update on progress made since the last review. NB: if no progress has been made, do not make it up. |
| Monitoring / Assurance | • How you are going to monitor that the controls in place are effective in managing the risk<br>Plus<br>• Evidence that shows risks are being reasonably managed |
| Predicted Residual Risk | • The risk rating after the further actions have been implemented: expressed as the product of the likelihood x the consequence |
| Initial Target Date | • Realistic date by which you consider the proposed actions will be completed |
| Revised Target Date | • A revised date should the initial target date not be achieved. A reason for this revised target date must be provided |
| Risk Owner | • This is you and you should<br>○ Understand the risk and monitor it through its lifetime<br>○ Ensure the appropriate controls are enacted<br>○ Report on the risk whenever required to do so |
| Responsible Committee | • The Committee which has responsibility for monitoring progress of the management of the risk |

| CONSEQUENCE SCORE (1 – 5) | 1<br>Insignificant/None (Green) | 2<br>Minor (Yellow) | 3<br>Moderate (Amber) | 4<br>Major (Red) | 5<br>Extreme (Red) |
|---|---|---|---|---|---|
| **Injury (physical / psychological)** | Adverse event leading to minor injury not requiring first aid and managed satisfactorily on the ward | Minor injury or illness, first aid treatment needed Staff sickness <3 days | RIDDOR / Agency reportable. Adverse event which impacts on a small number of people | Major injuries or long term incapacity / disability (e.g. loss of limb) | Incident leading to death or major permanent incapacity. Event which impacts on large numbers of people |
| **Additional Guidance** | Bruise/graze (no time off work) | Laceration, sprain. Anxiety requiring counselling (less than 3 days off work) | Injury requiring more than 3 days off work/admission < 24hrs | Fractured of major bone, loss of limb, post-traumatic stress disorder | Death, paralysis |
| **Quality of the patient experience / outcome** | Reduced quality of patient experience not directly related to delivery of clinical care | Unsatisfactory patient experience directly related to clinical care – readily resolvable | Mismanagement of patient care + short term effects (less than a week) | Mismanagement of patient care + long term effects (more than a week) | Totally unsatisfactory patient outcome or experience |
| **Additional Guidance** | Outpatient clinic waits | Drug error with no apparent adverse outcome, grade 1 pressure ulcer | Increased length of stay less than 1 week. HAI (short term) Grade 2/3 pressure ulcer | Increased length of stay more than 1 week. Long term HAI. Grade 4 pressure ulcer | Infant abduction. Removal of wrong body part leading to death or permanent incapacity |
| **Complaints / Claims** | Locally resolved complaint | Justified complaint peripheral to clinical care | Below excess claim. Justified complaint involving lack of appropriate care | Claim above excess level. Multiple justified complaints | Multiple claims or single major claim |
| **Staffing and Competence** | Short term low staffing level (<1 day), where there is no disruption to service | Ongoing low staffing levels resulting in minor reduction in quality of care | Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing problems with staffing levels | Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training | Non-delivery of key objective / service due to lack of staff. Critical error due to insufficient training |
| **Service / Business Interruption** | Interruption in a service which does not impact on the delivery of care or the ability to continue to provide the service<br><br>Trust would not encounter any significant accountability implications | Short tem disruption to service with minor impact on care<br><br>Some accountability implications but would not affect Trust's ability to meet key reporting requirements | Some service disruption with unacceptable impact on care. Non-permanent loss of ability to provide service<br><br>Trust may experience difficulty in complying with some key reporting requirements | Sustained loss of service with serious impact on delivery of care: major contingency plans involved<br>Trust would be unable to comply effectively with the majority of its reporting requirements.<br>Recovery would be highly complicated and time-consuming | . Permanent loss of core service or facility. Disruption to facility leading to significant 'knock-on' effect across Local Health Economy<br><br>Trust would be unable to meet key reporting requirements<br><br>Recovery would be extremely complicated |
| **Projects / objectives** | Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality | < 5% over budget / schedule slippage. Minor reduction in quality / scope | 10% over budget / schedule slippage. Reduction in scope or quality | 10 – 24% over/ under budget/ schedule slippage. Does not meet secondary objectives | > 25% over /under budget / schedule. Doesn't meet primary objectives. Reputation of the Trust seriously damaged. Failure to appropriately manage finances |
| **Financial** | Small loss | Loss < 5% of budget | Loss < 10% of budget | Loss of 10 – 25% of budget | Loss of > 25% of budget |
| **Inspection / Audit** | Small number of recommendations which focus on minor quality/ process improvement issues | Minor recommendations which can be addressed by low level of management action | Challenging recommendations but can be addressed with appropriate action plan | Enforcement Action. Critical report / low rating | Prosecution. Zero Rating. Severely critical report |
| **Adverse Publicity / Reputation** | Coverage in the media, little effect on public confidence / staff moral<br><br>Public perception of the organisation would remain intact | Local media – short term. Minor effect on public attitude / staff morale<br><br>Public perception of the organisations may alter slightly but with no significant damage or disruption | Local media – long term.<br><br>Considerable adverse public reaction / staff morale may be affected | National media < 3 days. Usage of services affected<br><br>Public confidence in trust undermined: could result in major problems | National media > 3days. MP concern (questions in the House)<br><br>Major adverse public reaction |
| **No. Of Persons Affected** | N/A | 1-2 | 3-15 | 16-50 | >50 |

| Consequence | Description |
|---|---|
| Insignificant | Operational performance of the function/activity area would not be materially affected<br>The organisation would not encounter any significant accountability implications<br>The interests of stakeholders would not be affected<br>Public perception of the organisation would remain intact |
| Minor | Slight inconvenience / difficulty in operational performance of function/activity<br>Some accountability implications for the function/activity are but would not affect the organisation's ability to meet key reporting requirements<br>Recovery from such consequences would be handled quickly without the need to divert resources from core activity areas<br>Some minor effects stakeholders e.g. other sources or avenues would be available<br>Public perceptions of the organisation may alter slightly but with no significant damage or disruption occurring |
| Moderate | Operational performance of the organisation would be compromised to the extent that revised planning would be required to overcome difficulties experienced by function/activity area<br>The organisation would experience difficulty in complying with some key reporting requirements<br>Recovery would be gradual and required detailed corporate planning with resources being diverted from core activity areas<br>Stakeholders would experience some difficulty<br>Considerable adverse public reaction |
| Major | Operational performance of the function/activity area would be severely affected, with the organisation unable to meet a considerable proportion of its obligations.<br>The organisation would not be able to comply with the majority of its reporting requirements effectively<br>Recovering from the consequences would be highly complicated and time-consuming<br>Stakeholders would experience considerable difficulty<br>Public reaction could result in major problems |
| Serious | Operational performance would be compromised to the extent that the organisation is unable to meet its obligations<br>The organisation would be unable to meet key reporting requirements<br>The organisation would incur huge financial losses<br>Recovering from the consequences would be extremely complicated<br>Major adverse public reaction. |