TRUST BOARD PUBLIC – DECEMBER 2015

Agenda Item Number: 211/15
Enclosure Number: (5)

Subject:	Trust Risk Register
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Acting Head of Risk Management Cathy Stone – Director of Nursing Cathy Stone – Director of Nursing
Purpose of paper *Why is this paper going to the Trust Board*	Discussion requested by Trust Board Regular Reporting
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the RAC members should focus on including conclusions and proposals*	Trust Board are asked to note • Top risks • New risks 40-1516, 41-1516 and 42-1516
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the top risks from the Trust Risk Register and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Register
Next steps / future actions: *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 actioned as appropriate and reported to RAC in January 2016.
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 13 November 2015

Top Risks

15-1415 ◄► (20): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing.

26-1516 ◄► (20): The Trust is unable to achieve its planned year end financial position 2015/16

30- 1415◄► (20): Stroke service pathway (including follow up after discharge) commissioning and provision (medical, therapy and nursing) is sub-optimal and non-sustainable in current format.

42-1516 ◄► (20): Lack of reporting capacity in Radiography to report ED and MAU plain films.

13-1516 ◄► (16): The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED.

20-1415 ◄► (16): Review of delivery of colorectal service model of care to achieve optimum patient experience current workforce instability impacting on delivery of required performance..

32-1415 ◄► (16): QA@home increases demand on pharmacy resources and expenditure and impacts on patient safety.

33-1415 ◄► (16): Inability to recruit to vacant post within the DSC post TUPE with reduced resilience for sustainability of the service due to difficulty in recruiting to a specialist area.

39-1516 ◄► (16): Insufficient theatre capacity to meet planned demand

36-1516 ◄► (15): Lack of robust identification of clinicians and doctors taking responsibility for blood tests and the lack of audit and review around filing and viewing results.

Risks with Increased Score

Nil

Risks with Decreased Score

Nil

New Risks

40-1415 NEW (Amber 8): Physical and operational fire precaution deficiencies.

41-1516 NEW (Yellow 6): Fire sprinkler installations require updating to a compliant life safety system.

42-1516 NEW (Red 20): Lack of reporting capacity in Radiography to report ED and MAU plain films.

Risks to be Removed

Nil

Target Date Changes

Nil

Of Note

Risks 01-1415, 11-1415 and 34-1516 re-described

Prepared by: Annie Green – Acting Head of Risk Management

Presented by: Cathy Stone – Director of Nursing

Trust Risk Profile – End October 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			41-1516 Sprinkler replacement ***NEW***	9-1516 Quality requirement ◄ ► 10-1516 Unintended consequences of CIP ◄ ► 19-1415 Cancer wait targets ◄ ► 40-1516 Fire precaution deficiencies ***NEW***	
Possible (3)			7-1415 Non-Luer spinal devices ◄ ► 22-1415 Provision of discharge summaries to GPs ◄ ► 23-1415 Increased vacancies and NHSP fill rate ◄ ► 37-1516 Patient transport ◄ ► 38-1415 Clinical Coding ◄ ►	1-1415 Use of Non-Buying Solutions agencies ◄ ► 3-1516 Healthcare associated infection trajectories ◄ ► 4-1415 Loss/disclosure of PID ◄ ► 8-1516 Risk of patient injury following inpatient falls / CQUIN ◄ ► 18-1415 7 day Working ◄ ► 16-1516 Data Quality ◄ ► 17-1415 Outliers ◄ ► 21-1415 MCA and DOLs safeguards ◄ ► 24-1415 Essential Skills Training ◄ ► 27-1415 Cash Liquidity ◄ ► 34-1516 Typing Issues ◄ ►	
Likely (4)			11-1415 Concerns with Health Record function ◄ ► 12-1415 Sewage flooding ◄ ►	13-1516 National and local access targets ◄ ► 20-1415 Colorectal Service model of care ◄ ► 32-1415 QA@H pharmacy resource ◄ ► 33-1415 DSC vacancy and sustainability of service ◄ ► 39-1516 Insufficient theatre capacity ◄ ►	30-1415 Stoke Service ◄ ►
Highly Likely (5)			36-1516 Review of test results ◄ ►	15-1415 ED queue and Trust bed capacity ◄ ► 26-1516 Year end financial position ◄ ► 42-1516 ◄ ► Lack of reporting capacity in Radiography	

TRUST RISK REGISTER 2015/16 – PROGRESS SUMMARY – END OCTOBER 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
						APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
1,4	1-1415	RK	OB	Use of non-crown commercial service framework approved staffing agencies.		TOLERATE												Jan 16	12
1,3,4	3-1516	CM	ICMC	Trust fail to achieve objectives for reducing healthcare associated infections		20	12	12	12	12	12	12						Nov 15	12 Mar 16
1,3	4-1415	JT	IGSG	Potential loss /misdirection/inappropriate disclosure of personal data.		TOLERATE												Jan 16	12
1	7-1415	SE	MDMC	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		TOLERATE												Jan 16	3
1,3	8-1516	CM	PSSG	Risk of patient injury following inpatient falls due to failure to follow policy. Non delivery of patient safety CQUIN falls element		12	12	16	16	12	12	12						Dec 15	8 Apr 16
1,3	9-1516	CM	G&Q	Failure to achieve internal and external set quality/patient safety improvements		16	8	8	8	8	8	8						Nov 15	8 Mar 16
1,3,5	10-1516	CS	G&Q	Unintended consequences to delivery and quality of care due to cost improvement programme		8	8	8	8	8	8	8						Dec 15	8 Mar 16
1	11-1415	AF	RAC	Concerns with the condition of health records and growing issue of production of temporary sets of notes.		12	12	12	12	12	12	12						Jan 16	6 Jun 16
1,3,4	12-1415	JA	CCRG	Blockage of sewage services leading to flooding within departments, predominantly Paediatrics		6	6	6	12	12	12	12						Dec 15	6 Dec 15
1,3,5	13-1516	MD	OB	The Trust fails to achieve key local and national access standards and targets.		16	16	16	16	16	16	16						Dec 15	12 Jun 16
1,3,4	15-1415	GM	OB	Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing		20	20	20	20	20	20	20						Nov 15	12 Dec 15
3,5	16-1415	MK	OB	Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate		12	12	12	12	12	12	12						Jan 16	8 Jun 16
1,3,4	17-1415	MQ	SMT	At times of high capacity decisions are made to move patients out of their specialty foot print for the provision of their care		20	12	12	12	12	12	12						Jan 16	12 review Jan 16
1,3	18-1415	SH	SMT	Lack of equivalent workforce across seven days of the week		12	12	12	12	12	12	12						Dec 15	8 Apr 16
1,3	19-1415	NM	SMT	Failure to achieve cancer wait targets		8	8	8	8	8	8	8						Dec 15	8 Apr 16

1,3	20-1415	NM	TB	Review of delivery of colorectal service model of care to achieve optimum patient experience		16	16	16	16	16	16	16						Dec 15	8 Dec 16
1,3,4	21-1415	AT	SC	Mental capacity act (MCA) and deprivation of liberty safeguards		16	16	16	16	16	12	12						Nov 15	8 Nov 15
1,3	22-1415	CT	RAC	The Trust requirement to use Vitalpac to generate an electronic discharge summary for all patients is experiencing delays in implementation and where it is in use the time taken to complete is impacting on Junior Doctor working times		9	9	9	9	9	9	9						Dec 15	6 Dec 15
1	23-1415	NS	NW/HR R C	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. Aggressive recruitment continues however march – sep is a difficult time to recruit large numbers		9	9	9	9	9	9	9						Nov 15	9 review Sep 15
1	24-1415	RK	SMT	Completion of face-to-face essential skills training falls below 85% which is the acceptable level to the trust board. This includes: Manual handling, Fire awareness Basic life support and Blood awareness		12	12	12	12	12	12	12						Jan 16	4 Apr 16
3,5	26-1516	LW	FC	The Trust is unable to achieve its planned year end financial position 2015/16		16	16	16	16	16	20	20						Nov 15	12 Mar 16
3,5	27-1516	LW	FC	The Trust is unable to maintain sufficient liquidity/cash		9	12	12	12	12	12	12						Nov 15	9 Mar 16
1,3,4	30-1415	LF	SMT	Stroke service pathway (including follow up after discharge) commissioning and provision (medical, therapy and nursing) is sub-optimal and non-sustainable in current format		20	20	20	20	20	20	20						Nov 15	10 Nov 15
1,3,4	32-1415	AC	QA@H GC	QA@home increases demand on pharmacy resources and expenditure and impacts on patient safety		16	16	16	16	16	16	16						Dec 15	**8 Mar 16**
1,3,4	33-1415	HW	CSC GC	Inability to recruit to vacant post within the DSC post TUPE with reduced resilience for sustainability of the service due to difficulty in recruiting to a specialist area		16	16	16	16	16	16	16						Nov 15	**8 Nov 15**
1,3,4	34-1516	AF	CSC GC	Quality of typing transcription is variable			12	12	12	12	12	12						Jan 16	8 May 16
1,3,4	35-1516	AC	CSC GC	Lack of capacity to supply medicines under section 10 or for clinical trials from manufacturing unit			16	16	16	16	16	8	Risk to be removed					Sep 15	8 Sep 15
1,3,4	36-1516	CJ	OB	Lack of robust identification of clinicians and doctors taking responsibility for blood tests and the lack of audit and review around filing and viewing results					15	15	15	15						Dec 15	9 Dec15
1,3,5	37-1516	HW	OB	Non-compliance with current CSU commissioned patient transport booking processes					9	9	9	9						Nov 15	6 Dec 15
1,3,5,	38-1516	JA	CSS Gov	Delay in migration to 3m Medicode clinical coding system					12	12	9	9						Dec 15	6 Mar 16
1,3,5	39-1516	NM	S&C Gov	Insufficient theatre capacity to meet planned demand							16	16						Nov 15	8 Mar 16
1,3,4	40-1516	JA	CCRG	Physical and operational fire precaution deficiencies. (Maybe identified ad hoc or by programmed risk assessments)								8						Feb 16	4 Apr 17
1,3,4	41-1516	JA	FCCRG	Fire sprinkler installations require updating to a compliant life safety system.								6						Feb 16	3 Jun 16
1,3	42-1516	AF	OB	Lack of reporting capacity in Radiography to report ED and MAU plain films.								20						Jan 16	8 Aug 16

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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											Review Date	Target Date	
13-1516	C/F/Q&P/R/SD – Risk Assessment	Oct 12	THE TRUST FAILS TO ACHIEVE KEY LOCAL AND NATIONAL ACCESS STANDARDS AND TARGETS EXCLUDING ED.	• Patient experience • Patient safety • Quality/clinical outcomes • Trust financial position • Trust reputation	• Weekly specialty PTL meetings led by CSC GM. • Weekly assurance meeting chaired by Deputy COO/Head of Performance • Performance team co-ordination of breach position at Trust aggregate level • RTT compliance plans and 35 week recovery plans for all "at risk" specialties –reviewed weekly • Increased use of ISTC to support gaps in capacity • Theatre scheduling policy and cancellation day of surgery policy • Update • Weekend operating sessions programme in place • Diagnostic recovery and resilience plan	8 4x2	16 4x3	8 4x2	• Referrals and CQUIN plans monitored weekly at ODG to facilitate "early warning" of capacity / demand problems • OP transformation project launched and ongoing • Theatres transformation project led by PMO • Detailed RTT compliance recovery strategy being developed for TB approval • Business case to increase capacity • Update • Recruitment plans- Superceded by strategic changes in spinal service. Awaiting outcome of discussions with SUHT. • Colorectal service recruitment under review • Validation 1st phase completed in Gastro with positive impact. Further phase commenced.	• Activity plans to meet GURROO 3 model. Including growth plans • Performance dashboard and weekly assurance meeting • Reports to TDA, Commissioners and Trust Board	Dec 2015	Jun 2016	M Dixon SMT

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15-1415	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 .	• Clinical safety of patients • Reputation of Trust compromised • Patients not having initial assessments within 15 minutes and not seeing doctor within one hour of arrival. • Financial penalties linked to ambulance handover times and non - achievement of 4 hour target • Poor privacy, dignity and overall patient experience as little or no facilities available in ED corridor, • Unsuitable environment for patients • Staff stress • Potential for increased errors • Inability to achieve Emergency care quality standards	• CSC Strategy • CSC Strategy • PHT Unscheduled Care Quality Improvement Plan ratified by UCB and PHT Trust Board Phase II with implementation timetable • 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours) • Enhanced role of ED Nurse in Charge to reduce 4hr breaches • Update • Ambulatory Emergency care to be moved to dedicated ring fenced area • AMU Orange – 22 beds to be re-introduced to assessment bed stock to allow post taking to move from ED and off 4hr clock	25 5x5	20 5x4	12 4x3	• Trust recovery plan to be fully implemented • Review and enhance MDT Discharge Processes to increase daily discharge • Medical wards to review criteria for admission increasing availability of bed stock to ED/AMU • Mapping of frailty pathway commenced to agree WHE frailty strategy • Auditing of internal professional standards • WHE KPIs to monitor performance against Phase II WHE plan – agreed and plan well underway • Update • Frailty Intervention Team (FIT) Business care for approval end October 2015	• ODG • Trust Board • Reviewed at Trust Recovery Group and monthly by TDA • Operational Delivery Group • Transformation programme commenced • Plan monitored weekly by Urgent Care Quality Improvement Group and chaired by CEO.	Nov 2015	Dec 2015	G Macdonald SMT

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20-1415	Risk Assessment	Dec 2013	REVIEW OF DELIVERY OF COLORECTAL SERVICE MODEL OF CARE TO ACHIEVE OPTIMUM PATIENT EXPERIENCE CURRENT WORKFORCE INSTABILITY IMPACTING ON DELIVERY OF REQUIRED PERFORMANCE	• Poor quality of care and patient experience • Failure to meet RTT and cancer targets • Trust reputation	• PLL meetings for RTT and Cancer • New processes following action plan for 2014 have been implemented • Mediation agreement reached June 2014 • Monthly department meetings. • Update • Service moved into special measures with Medical Director acting as Clinical Lead/Director and Director of Operations for Scheduled Care acting as General Manager. Management removed from CSC • Clinical Fellow in post • Consultant locums x 2 in post until 2016 • Additional OPD capacity being operationalized by movement of Pain Service, to support changes in workforce and job planning.	12 4x3	16 4x4	8 4x2	• Continuing actions to manage waiting times for cancer and RTT patients • Recovery plan in place for RTT. • Additional activity for outpatient clinics being undertaken ad hoc basis • Update • Individual strategy meetings held with MD and DoO, agreed vision for service • Detailed job planning programme to commence November 2015 • Requirements of work patterns of consultant team members identified by MD and awaiting final outcome • Meeting with Consultant team scheduled for Oct to agree requirements for 2 x substantive posts to stabilize team • Specialist nursing roles to be reviewed by external adviser to ensure appropriate for service Planned for end November 2015. • Cancer pathways to receive external support, benchmarked regionally to improve delivery. Planned for November 2015 • Enhanced recovery programme being reviewed and relaunched by external specialist nurse, supported by lead clinicians to improve patient experience and length of stay	• Review by Executive team • Update • Review by Medical Director and Director of Operations Scheduled Care • Weekly meetings with D of Ops instigated to address any outstanding and new service delivery/performance issues.	Dec 2015	Dec 2016	M Dixon **Trust Board**

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26-1516	F / R – Assessment	Oct 2011	The Trust is unable to achieve its target financial position for the year 2015/16 of a planned deficit of £9.7m on Income and Expenditure	• Potential for TDA intervention • Potential for liquidity (cash) problems • Potential for measures being required that might risk posing a detrimental effect on services • Reputational, perceived as a failing organization • Jeopardise successful FT application • Failure to comply with the TDA's 'stretch' limit of £9.7m set to improve the aggregate bottom line revenue position for the NHS Trust sector	• **Monthly performance meetings:** Finance reporting and monitoring mechanisms at CSC to Board level • **Pay:** Controls include, budget monitoring and control, workforce strategy committee, temp staffing review meetings and Executive sign off for temporary posts. • Corporate recruitment requires executive sign off from June. • **Non Pay:** Controls include budget monitoring, agreed authorisation levels technical approvers for specific categories. • **Income & Contract Penalties (inc CQUIN):** Controls include, contract monitoring reports and meetings, income assurance group with CSC's. • Regular CQUIN meetings with CSCs to assess performance. • **CIP programme:** Controls include monthly reports and Transformation Office oversight. • Controls include budget monitoring and monthly performance reviews with Exec team • Visibility of Financial Information through Qlikview	**12** **4x3**	**16** **4x4**	**12** **4x3**	• Rolling forecast to be regularly updated and subject to rigorous review and challenge. • Update • Recovery plan continues to be reviewed and developed to achieve the stretch target of £9.7m (ongoing)	• Monthly reporting to all relevant meetings (EMT, SMT, Finance Committee & Trust Board) • Greater CSC Scrutiny at Finance Committee re action plans and assurance of recovery of the position	Nov 2016	Mar 2016	Lee Williams **FC**

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30-1415	C/F/R/Q&P/SD Risk assessment	December 2014	FAILURE TO MAINTAIN THE STROKE SERVICE PATHWAY • Thrombolysis door to needle time • Staffing levels on the HASU including continuity of Consultant care • Maintaining 90%direct admission and 90% LOS • Lack of Stroke follow up clinic	• Potential for patient harm and poor patient experience due to: • Delay door to needle tim • Failure to meet national targets and quality indicator • Negative impact on SSNAP score • Increase in aspiration pneumonia • Delay in recognizing thrombolysis complications • Failure to meet national standards level 2 nursing care • Reputation to Trust/Stroke Service	• New SPR rota commenced 06/02/15 • Nursing recruitment / training • Business case has been approved to increase nursing staff levels • Stroke operational policy in progress to be ratified and agreed • Increase to Stroke nurse Coordinator/ reviewing current skills and training required • Robust governance structure to review patient pathway • Escalation to medical director	**20 5x4**	**20 5x4**	**10 5x2**	• June 2015: Stroke action plan implementation in progress • Meeting planned with neighboring Trusts ambulance service and PHT stakeholders to review the Stroke Pathway for Portsmouth • Recruitment in progress for nursing staff/ Stroke Coordinator • Plan to increase bed capacity by swapping F2/ F4- completed July 2015	• Dr Foster data scrutiny • Monthly thrombolysis review meeting and mortality meetings • Ongoing monitoring of patient experience via complaints and Friends and Family Test. • Stroke Lead Action Group reviewing and escalating to MOPRS SM • SSNAP data improved from E to D (January-March Data) • Dr Foster data scrutiny	Nov 2015	Nov 2015	L Field **MOPRS SMT and Stroke Lead Group**

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32-1415	C/F/R/Q&P/SD Risk assessment	February 2015	• QA@Home – Lack of pharmacist capacity to deliver ongoing clinical service to all patient safety and monitoring of medication. • Patients discharged rather than transferred therefore unable to have accurate patient list. • Increase demand for NOMADS for patients awaiting Social Care • QA@home increases demand on pharmacy resources and expenditure. • Suggested increase to 30 beds puts more patients at risk of harm from medication errors	• Potential harm to patients due to lack of pharmaceutical optimization • No definitive list of patients • Increased work load for pharmacy and consequential knock on effect on nursing staff due to lack of single access point • Delay in dispensing of changes to prescriptions for patients at QA@home	• Patients TTOs dispensed at time of transfer to QA@home • Complex patients requiring NOMADS will not be frequent users of the service • All patients accessing QA@home for IVabs will be reviewed by Microbiology prior to transfer • No patients will be transferred on regular aminoglycosides • Weekly microbiology & pharmacist review of patients on IVabs	**16 4x4**	**16 4x4**	**8 4x2**	• To review if the service grows in size to consider a business case for a link pharmacist resource for QA@home • Process to prompt review from QA@Home to ward pharmacist to be developed to highlight patients who have clinically changed – disregarded as appropriate due to visits being undertaken by non-nursing healthcare professionals who do not have the necessary clinical skills and knowledge to prompt a review • Appointment of pharmacist to cover QA@Home patients • Requires further discussion regarding service provision expansion and funding stream. • Appointment of pharmacist to cover QA@Home patients - job description complete, requires WSC approval. • No governance meetings for many months and not aware next will run.	• Monthly Clinical Governance Review Group • Monthly Contract Review Group • Monthly review of Datix and incident reporting for medications by Head of Quality & Medication Safety Pharmacist	Dec 2015	Mar 2016	A Cooper **QA@H Governance Committee**

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33-1415	C/F/R/Q&P/SD Risk assessment	February 2015	INABILITY TO RECRUIT TO VACANT POST WITHIN THE DSC POST TUPE WITH REDUCED RESILIENCE FOR SUSTAINABILITY OF THE SERVICE DUE TO DIFFICULTY IN RECRUITING TO A SPECIALIST AREA.	• In February 2015 there will only be 1 band 7 for 2 days per week total 15 hrs. • Erosion of rotating therapist to this service has reduce the ability to back fill • Agency support is in practical as there is no level of skill suitable and none that can fit within a small specialist team • Increase in waiting list time. This is currently creeping to - 8 weeks and is set to deteriorate rapidly as staff go on maternity leave end of March • PHT will need to consider notification to NHS England that the department is unable to meet the criteria of the Murrison Centre. Potentially PHT are at risk of losing that status with the Qudos/reputation and significant funding that PHT have benefited from. This will have to be an early escalation in January 2015	• Additional hrs. have been offered by the Centre paid for by the veterans fund • Current staff cannot extend their secondments to DSC as required to return to their specialties to back fill vacancies within other specialties namely MSK • Clinical Support has been approached to request that the amputee nurse specialist who is currently moving to tissue viability is released for a half a day per week until mid-February to support the DSC wound pathway to help elevate waits and or unnecessary determination of complex wounds,. This has been agreed. • A risk share agreement has been reached as an interim for 50 :50 share of the costs with the association resources required,	**16 4x4**	**16 4x4**	**8 4x2**	• Agree 50 50m share of costs for increased resources. • Recruit to vacant band 3 post • Utilize the current band 7 post to support enhanced rotation at band 5 and band 6 level • Address with the commissioners who should fund the service going forward • The band 5 rotation is in place but still no plan to cover the band 6 maternity leave and still no plan to cover the vacant band 7 which has happened since the last escalation. • Contractual negotiations have continued with Solent with a resolution that those therapy staff left at DSC and AMDH will TUPE .CS are taking this forward. • Rotational posts at band 5 are in post with Increased hrs to support a more robust skeletal service in the short term. • Looking to TUPE staff in September 2015 - • TUPE should be completed by end of November 2015	• Open dialogue between Solent and PHT finance contracting team to reach a swift resolution • Open dialogue with the Solent therapy team to work with a flexible model in order to grow the service	Nov 2015	Nov 2015	Hayley Wagner **CSC Governance Committee**

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36-1516	Clinical / Assessment	July 2015	CURRENTLY THERE IS A HIGH RISK AROUND THE IDENTIFICATION OF CLINICIANS AND DOCTORS TAKING RESPONSIBILITY FOR BLOOD TESTS AND THE LACK OF AUDIT AND REVIEW AROUND FILING AND VIEWING RESULTS. There are 2 systems in place to review blood review results but APEX cannot log information as to who reviewed the results. ICE can produce audit trails but we need to ensure Doctors are checking results daily. This is currently not happening.	• Patient safety, if results are not checked in a timely manner. • No audit trail if an incident happens.	• ICE instead of APEX for external partners has been instigated • IT department educated as to licence allocated	**15** **3x5**	**15** **3x5**	**9** **3x3**	• Change training of ICE to include more education around lack of controls in APEX • Pilot in place in MOPRS start 3rd August 2015 for 4 weeks. This pilot will make it mandatory for all junior docs to log into ICE once per day • The pilot will assess: • Additional time it takes to log in each day •Load on time and effort •Any technic al issues to be addressed	• Project lead to monitor and complete outcome of review • Risk assurance committee to monitor • Project lead to feed back to Risk assurance committee in October 2015	Dec 2015	Dec 2015	Chris James **OB**

ID / CQC 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 / Final target date for mitigation of risk (RAG rated for progress: On target; Minor obstacle to achieving target; Inability to achieve predicted target)		RESPONSIBLE LEAD / COMMITTEE
											Review Date	Target Date	
39-1516	C/Q&P/SD/R – CSC Risk Register	01/04/15	INSUFFICIENT THEATRE CAPACITY TO MEET PLANNED DEMAND	• Increase in patient delays • Inability to meet 18 week RTT target • Increase in complaints • Financial liability if fail to achieve targets • Trust reputation	• Reviewed as part of business planning and additional list requirement remodeled • Active management of PTL by Access centre • Activity and performance data reviewed by CSC Board weekly • Additional list requirement submitted to executive team.	**16 4x4**	**16 4x4**	**8 4x2**	• Capacity shortfall in some specialties remains, additional lists arranged for backlog clearance • Additional lists should be available in October. • Options for longer days and weekend working being explored	• Weekly PTL meeting • Waiting list review	Nov 2015	Mar 2016	N Martin **S&C Governance**
42-1516	C/Q&P/SD/R – Risk Assessment/Incidents		LACK OF REPORTING CAPACITY IN RADIOLOGY TO REPORT ED AND MAU PLAIN FILMS.	• Impact on patient outcome through missed or delayed diagnosis. • Trust reputation	• Whilst the PHT plain film reporting and evaluation policy states Diagnostic Imaging will undertake the routine reporting of Emergency department "normal" examinations, it is recognised that there is insufficient capacity to deliver this. • The Emergency Department are aware that advice can be sought via the Radiology Access Unit and the results service for any images where an immediate radiological opinion is required. • In addition, whilst radiographers do not provide a radiological opinion they will, if able, highlight pathology to the referrer.	**20 4x5**	**20 4x5**	**8 4x2**	• Contact other Trusts to see how they have addressed Plain film reporting capacity. - completed • Return to RAC Oct 5th 2015 with outcome of above and potential options for further discussion – plan to be developed by Dec 15	• CSC Clinical Governance Meeting • Operational Board • RAC	Jan 2016	Aug 2016	A Fitzsimons **CSS CSC Governance**

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
JA	John A'Court		CS Gov	Clinical Services Governance Committee		CSC	Clinical Service Centre
DB	Deborah Burrows		CCRG	Combined Contract Review Group		CSL	Carillion Services Limited
AC	Amanda Cooper		G&Q	Governance & Quality Committee		CQC	Care Quality Commission
SE	Sean Elliot		FC	Finance Committee		CRB	Criminal Records Bureau
AF	Alison Fitzsimmons		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
NM	Natasha Martin		ITSG	Information Technology Steering Group		OBC	Outline Business Case
CM	Caroline Mitchell		MDMC	Medical Devices Management Committee		PID	Person Identifiable Data
RP	Robert Porter		MHLG	Mental Health and Learning Disabilities Group		NHSP	National Health Service Professionals
TP	Tim Powell		NW/HR RC	Nursing Workforce/ HR Risk Committee			
CT	Chris Tite		PEWG	Patient Experience Working Group			
JT	James Taylor		PSSG	Patient Safety Steering Group			
HW	Hayley Wagner		SC	Safeguarding Committee			
LW	Lee Williams		SMT	Senior Managers Team			
			WSC	Workforce Strategy Committee			

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

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. • 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 o Likelihood: the likelihood of the risk happening - this score should take into account the existing controls o 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 • 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 Plus • 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 o Understand the risk and monitor it through its lifetime o Ensure the appropriate controls are enacted o 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 Insignificant/None (Green)	2 Minor (Yellow)	3 Moderate (Amber)	4 Major (Red)	5 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 Trust would not encounter any significant accountability implications	Short tem disruption to service with minor impact on care 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 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 Trust would be unable to comply effectively with the majority of its reporting requirements. 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 Trust would be unable to meet key reporting requirements 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 Public perception of the organisation would remain intact	Local media – short term. Minor effect on public attitude / staff morale Public perception of the organisations may alter slightly but with no significant damage or disruption	Local media – long term. Considerable adverse public reaction / staff morale may be affected	National media < 3 days. Usage of services affected Public confidence in trust undermined: could result in major problems	National media > 3days. MP concern (questions in the House) 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 The organisation would not encounter any significant accountability implications The interests of stakeholders would not be affected Public perception of the organisation would remain intact
Minor	Slight inconvenience / difficulty in operational performance of function/activity Some accountability implications for the function/activity are but would not affect the organisation's ability to meet key reporting requirements Recovery from such consequences would be handled quickly without the need to divert resources from core activity areas Some minor effects stakeholders e.g. other sources or avenues would be available 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 The organisation would experience difficulty in complying with some key reporting requirements Recovery would be gradual and required detailed corporate planning with resources being diverted from core activity areas Stakeholders would experience some difficulty 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. The organisation would not be able to comply with the majority of its reporting requirements effectively Recovering from the consequences would be highly complicated and time-consuming Stakeholders would experience considerable difficulty 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 The organisation would be unable to meet key reporting requirements The organisation would incur huge financial losses Recovering from the consequences would be extremely complicated Major adverse public reaction.