Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC - MAY 2015

Agenda Item Number: 97/15
Enclosure Number: (6)

Subject:	Trust Risk Register
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Senior Risk Advisor 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 • Decrease of risks 10-1415 and 27-1415 • Risk 10-1415 to be considered for removal from Trust Risk Register • Risk 8-1415 revised for 2015/16 • New risks
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 June 2015.
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 15 May 2015

Top Risks

3-1415 ◄► (20): Trust fail to achieve objectives for reducing healthcare associated infections

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

17-1415 ◄► (20): At times of high capacity decisions are made to move patients out of their specialty foot print for the provision of their care

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

2-1415 ◄► (16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode

13-1415 ◄► (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

21-1415 ◄► (16): Mental capacity act (MCA) and deprivation of liberty safeguards

26-1415 ◄► (16): The Trust is unable to achieve its planned year end financial position 2014/15

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

29-1415 ◄► (15): Patient admitted to Trust with possible viral haemorrhagic fever (VHF)

Risks with Increased Score

Nil

Risks with Decreased Score

10-1415 ▼ (Amber 12 to Amber 8): Unintended consequences to delivery and quality of care due to cost improvement programme – all QIAs as part of transformation programme signed off.

27-1415 ▼(Amber 12 to Amber 9): The Trust is unable to maintain sufficient liquidity/cash – target met for 2014/15

New Risks

34-1516 (Red 16): Lack of capacity to supply medicines under section 10 or for clinical trials from Pharmacy Manufacturing Unit

35-1516 (Amber 12): Inconsistent typing transcription quality and turnaround

Risks to be Removed

10-1415 ▼ (Amber 12 to Amber 8): Unintended consequences to delivery and quality of care due to cost improvement programme – all QIAs as part of transformation programme signed off

Target Date Changes

2-1415 (Red 16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode – delays in Commissioners agreeing service provision.

3-1415 (Amber 12): Lack of technical fire risk assessments throughout the whole of both new and retained estates and associated remedial works – delay in completion of assessments impacts on review of report findings by PFI parties

21-1415 ◄► (16): Mental capacity act (MCA) and deprivation of liberty safeguards – delay in securing admin support

Of Note

8-1415 (Amber 12): Risk of patient injury following inpatient falls due to failure to follow policy. Non delivery of patient safety CQUIN falls element – risk revised for 2015/16

Prepared by: Annie Green – Senior Risk Advisor

Presented by: Cathy Stone – Director of Nursing

Trust Risk Profile – End April 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			12-1415 Sewage flooding ◄ ►	10-1415 Unintended consequences of CIP ▼ 19-1415 Cancer wait targets ◄ ►	
Possible (3)			6-1415 Impact of software upgrades◄ ► 7-1415 Non-Luer spinal devices ◄ ► 22-1415 Provision of discharge summaries to GPs ◄ ► 23-1415 Increased vacancies and NHSP fill rate◄ ► 27-1415 Cash Liquidity▼	1-1415 Use of Non-Buying Solutions agencies◄ ► 8-1516 Risk of patient injury following inpatient falls / CQUIN 18-1415 7 day Working ◄ ► 4-1415 Loss/disclosure of PID ◄ ► 5-1415 Fire risk assessments ◄ ► 16-1415 Data Quality ◄ ► 24-1415 Essential Skills Training ◄ ► 27-1415 Cash Liquidity◄ ► 35-1516 Typing quality and delay ***NEW***	29-1415 VHF ◄ ►
Likely (4)			11-1415 Concerns with Health Record function ◄ ►	2-1415 Access to specialist mental health assessment ◄ ► 9-1415 Quality requirement ◄ ► 13-1415 National and local access targets ◄ ► 20-1415 Colorectal Service model of care ◄ ► 21-1415 MCA and DOLs safeguards ◄ ► 32-1415 QA@H pharmacy resource◄ ► 33-1415 DSC vacancy and sustainability of service ◄ ►	30-1415 Stoke Service ◄ ►
Highly Likely (5)				3-1415 Healthcare associated infection trajectories ◄ ► 15-1415 ED queue and Trust bed capacity ◄ ► 17-1415 Outliers ◄ ► 26-1415 Year end financial position ◄ ► 34-1516 PMU Capacity ***NEW***	

TRUST RISK REGISTER 2014/15 – PROGRESS SUMMARY – END APRIL 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
						JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN		
1,4	1-1415	RK	SMT	Use of non-crown commercial service framework approved staffing agencies.		TOLERATE												Apr 15	12
1,3,4	2-1415	FMcN	SC	Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode		12	12	16	16	16	16	16	16	16	16			Jun 15	12 Aug 15
1,3,4	3-1415	CM	ICMC	Trust fail to achieve objectives for reducing healthcare associated infections		16	16	16	16	20	20	20	20	20	20			Mar 15	16 Review for 15/16 End May 15
1,3	4-1415	JT	IGSG	Potential loss /misdirection/inappropriate disclosure of personal data.		TOLERATE												Jun 15	12
1,	5-1415	JA	F&SC	Technical fire risk assessments across the whole of the estate are not considered suitable and sufficient.		16	16	16	12	12	12	12	12	12	12			May 15	8 End May 15
1	6-1415	CT	IGSG	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		TOLERATE												Jun 15	6
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												Jun 15	3 Jun 15
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	12	16	16	16	16	16	16	12			Jun 15	8 Apr 16
1,3	9-1415	CM	G&Q	Failure to achieve internal and external set quality/patient safety improvements		12	12	12	12	12	12	12	16	16	16			Apr 15	8 Review for 15/16 End May 15
1,3,5	10-1415	FMcN	G&Q	Unintended consequences to delivery and quality of care due to cost improvement programme		12	12	12	12	12	12	12	12	8	Consider removal of risk			Apr 15	8 Apr 15
1	11-1415	AF	RAC	Concerns with health records function		12	12	12	12	12	12	12	12	12	12			May 15	6 Nov 15
1,3,4	12-1415	JA	CCRG	Blockage of sewage services leading to flooding within departments, predominantly Paediatrics		6	6	6	6	6	6	6	6	6	6			May 15	6 Review End May 15
1,3,5	13-1415	MD	SMT	The Trust fails to achieve key local and national		8	8	8	8	8	8	16	12	16	16			Apr 15	8 Review

				access standards and targets.															for 15/16 End May 15
1,3,4	15-1415	MP	SMT	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	20	20	20			May 15	12 Jun 15
3,5	16-1415	MK	MK	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	12	12	12			May 15	8 Jun 15
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		16	16	16	20	20	20	20	20	20	20			May 15	8 review End May 15
1,3	18-1415	SH	SMT	Lack of equivalent workforce across seven days of the week		12	12	12	12	12	12	12	12	12	12			Jun 15	8 Dec 15
1,3	19-1415	NM	SMT	Failure to achieve cancer wait targets		8	8	16	16	16	16	12	12	8	8			Jun 15	8 Apr 16
1,3	20-1415	NM	TB	Review of delivery of colorectal service model of care to achieve optimum patient experience		12	12	12	12	16	16	16	16	16	16			Jun 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	16	16	16	16	16			Jun 15	8 Sep 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	9	9	9			May 15	6 End May 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	9	9	9			Jul 15	9 review Jul 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	12	12	12			Jul 15	4 Apr 16
3,5	26-1415	LW	FC	The Trust is unable to achieve its planned year end financial position 2014/15		16	16	16	16	16	16	16	16	16	16			May 15	12 Review for 15/16 End May 15
3,5	27-1415	LW	FC	The Trust is unable to maintain sufficient liquidity/cash		9	9	12	12	12	12	12	12	12	9			May 15	9 Review for 15/16 End May 15
1,3,4	29-1415	RP	VHF PC	Patient admitted to trust with possible viral haemorrhagic fever (VHF)						15	15	15	15	15	15			May 15	5 end of world outbreak
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			Apr 15	10 Jul 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			Jun 15	**8 Jul 15**

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			Jun 15	**8 Jul 15**
1	34-1516	AC	MMC	Lack of capacity to supply medicines under section 10 or for clinical trials from manufacturing unit											16			Jul 15	**8 Oct 15**
1,3	35-1516	AF	RAC	Inconsistent typing transcription quality and turnaround											12			Jul 15	**8 May 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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											On target		
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2-1415 7	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 The way the service is currently set up can result in a complex and fragmented provision based on age and locality with gaps in inpatient psychiatry provision for adults of a working age No SLA with Solent for Responsible Clinician (RC) provision currently so gap in service and risk to compliance with the Mental Health Act requirements Lack of consistent provision of mental health advice regarding young persons	• Patient and staff safety • Organisational reputation	• 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. • Liaison team in place between 08:00 and 20:00; 7 days a week considered appropriate for activity • Mental health in acute setting on junior doctors rolling educational programme • Alcohol liaison service team MAU/ED • PHT representation on service review being conducted by Portsmouth City Integrated Commissioning Unit • Mental Health operational Group up and running – led by Lead Liaison nurse • OPMH service in place 7 days with 0.6wte consultant sessions • Mental Health Lead identified within DHMs reviewing completion of Section papers and follow up. • MH and LD committee reinstated	12 4X3	16 4X4	8 4X2	• Southern and Solent are in discussion to agree provision of RC cover. • Outsourcing MHA administration near completion: awaiting final costings. Contract to be signed by end of Feb 15. • Mental Health Act Policy drafted and out for consultation. • Consultation with Solent MH lead to assess Trust Compliance, training and supervision for DHMs who receive MHA papers on behalf of the Trust. – first meeting held now ongoing • Medical Director to formally write to Commissioners highlighting gaps in service provision as agreed at CQRM Update • Commissioners have responded and the Trust will be responsible for providing MH provision for in-patients (funded by tariff). The Trust is now working up a service specification. • Outsourcing MHA administration near completion: awaiting final costings. Contract to be signed by end of Feb 15. – complete, commences 01 June 2105 •	• Complaints and incidents – monthly exception report and quarterly quality performance report. • LD contract reporting • MH & LD Committee • G&Q Committee	Jun 2015	Aug 2015	F McNeight SC/MG&LD Committee

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3-1415 8	C / R / Q&P – Assessment	May 2012	TRUST FAILS TO ACHIEVE OBJECTIVES FOR REDUCING HEALTHCARE ASSOCIATED INFECTIONS (HCAIS). Objective of 0 (zero) avoidable MRSA bacteraemias Objective of 31 hospital acquired cases of C.Difficile. Failure to reduce hospital acquisition of other health care infections e.g. MSSA), E.coli bacteraemias etc Failure to control spread and acquisition of multidrug resistant infection e.g. VRE (vancomycin resistant enterococci), ESBLs (extended spectrum beta lactam producing prominence of Port Pec strains, and carbapenamase producing enterobacactereae Lack of timely laboratory diagnostics to allow the prompt identification of multi – drug resistant organisms Lack of isolation facilities in key clinical areas (e.g. renal), sub-optimal use of isolation facilities in other clinical areas due to poor bed management.	• Failure to meet quality performance indicators for CCGs, TDA • Failure to meet objectives results in financial penalties. • Failure to meet CQC standards (outcome 8) • Increased patient morbidity and mortality, readmission rate and LOS • Decreased patient experience • Loss of public and professional reputation • Potential Increase in litigation and complaints	• Monthly board exception report, annual DIPC report • Weekly infection dashboard to all CSCs • Daily list of infected patients and overdue devices to all senior clinicans. • Feedback of infection metrics at HoNs & MAC, PSWG, PEAG meetings • Multidisciplinary participation at ICMC • Multidiscilplinary RCAs for all sentinel infections • Infection prevention data presented to ODG. • Mandatory infection prevention training for all staff • Peer review of cleaning and soft FM standards. • Education of staff • Link Infection practitioner network • Participation at CSC governance and MM meetings • Prominent hand hygiene prompts throughout Trust • Infection prevention in all staff contracts • Participation in surveillance schemes to allow benchmarking of Trust performance • Targeted surveillance (real time) of HCAIs (VitalPac IPC-Manager) • On Call Infection Prevention Service • Introduction of Actichlor Plus as main disinfectant	12 4x3	20 4x5	16 4x4	• MRSA & C.Difficile action plan • Infection Control priorities 2014/15 • Action plans and learning from multi-disciplinary RCAs • Action plans to address specific CSC issues • CPE action plan • Position 2014/15 to date 2 cases MRSA against a trajectory of 0 C.Difficile year end objective failed • Risk to be revised for 2015/16 Update • Year end 2014/15 • MRSA – confirmed • 2 unavoidable • 0 avoidable • under arbitration 1 case • CDI – 40 cases (against 2014/15 trajectory of 31)	• Monitored by ICMC. Monthly exception reports to TB, weekly reports to ODG • Reports to Trust and CSC clinical governance committees, RAC and PSWG • Quarterly report to CCGs	Mar 2015	Risk to be revised for 15/16 May 15	Simon Holmes, Caroline Mitchell, **ICMC**

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9-1415 4 26	C, Q&P, R	June 2013	FAILURE TO ACHIEVE INTERNAL AND EXTERNAL SET QUALITY/PATIENT SAFETY IMPROVEMENTS High risk areas include • Achieving reduction in Red and Amber falls (CQUIN) • Achieving reduction in Grade 3 and 4 pressure ulcers (CQUIN) • Achieving Dementia Screening and assessment (CQUIN)	• Reputational damage • Potential fines • Patient safety	• Governance framework and monitoring – Quality Improvement framework • Performance and kit bag metrics • Monitor compliance framework • CSC Performance Reviews • Gov and Quality Committee and reporting timetable • Patient Safety Steering Group and associated workstreams • Clinical effectiveness Steering Group • Patient Experience steering Group • CQRM and quality contract reporting • Monthly and quarterly reporting to the Board • Monthly CQUIN meetings • Identified leads for all quality contract indicators • Dementia Steering Group	**12 4x3**	**16 4x4**	**8 4x2**	• Monthly monitoring of KPIs with HoN • Turnaround programme for reduction of falls and implementation of falls safe programme across Medicine CSC • Recovery plan for reducing pressure ulcers – weekly audits of Braden assessment and SKIN bundle compliance in place with monthly monitoring at HoN • FFT delivery plan in place • Daily monitoring of dementia screening with follow up emails to individual clinicians • Work in sepsis committee to mirror national patient safety initiatives on sepsis. Participation in national sepsis audit and internal evaluation of in house sepsis bundle Update • Failed medication year end target – 16 against target of 11 • 1 avoidable MRSA bacteraemia under arbitration with 1 pending PIR • Failed year end falls reduction target of 32 red and amber falls- year end total 43 with 8 outstanding investigations • Failed ED performance target at year end 2014/15	• Gov and Quality Committee • Patient Safety Steering Group • Clinical effectiveness Steering Group • Patient Experience steering Group • CQRM and quality contract reporting • Achieved Dementia Screening requirements in Q2 and Q3 to date	Apr 2015	Review for 15/16 May 2015	C Mitchell **G & Q**

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13-1415 4	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. • BI co-ordination of breach position at Trust aggregate level. • Trust-wide performance assurance processes • RTT compliance plans and 35 week recovery plans for all "at risk" specialties • Diagnostics "User Group" established to understand demand / capacity gap and agree on actions to improve waiting times • Weekly assurance meeting chaired by Head of Performance • Fortnightly/monthly monitoring of activity plans at ODG and CSC performance reviews • Support from TDA for aggregate fail for remainder of Q4 to support backlog reduction	8 4x2	16 4x3	8 4x2	• Referrals and CQUIN plans monitored weekly at ODG to facilitate "early warning" of capacity / demand problems • Recruitment plans monitored weekly and escalated as appropriate - ongoing • OP transformation project launched and ongoing • Theatres transformation project led by PMO • Detailed RTT compliance recovery strategy being developed for TB approval • Theatre scheduling policy and cancellation day of surgery policy produced, in draft, and shared with CSCs to improve management of cancellations of surgery – For ratification April 2015 • Diagnostic recovery and resilience plan Update • Demand/capacity gaps in Gastro for diagnostic and 2ww referrals	• RTT compliance plans and 35 week recovery plans for all "at risk" specialties • Activity plans to meet GURROO 3 model. Including growth plans • CSC performance review	Apr 2015	Review for 15/16 May 2015	SMT

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15-1415 4	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 • CEO chairing Urgent Care Task Force to oversee PHT recovery plan • ED IT System Go Live next 03 Mar 2015 • PHT Unscheduled Care Improvement Plan ratified by UCB and PHT Trust Board with 3 Phase implementation timetable • Transformation programme commenced	25 5x5	20 5x4	12 4x3	• Trust recovery plan to be fully implemented • Consultation process commenced to bring patient flow/bed management under central Ops team working to Trust wide bed declaration plan – policy to be ratified at SM • 7 point action plan agreed with Commissioners and Community Providers to increase discharge • ED IT System Go Live April 2015 • Plan to increase ACE spaces to increase admissions avoided • Create AMU Short Stay ward to decrease LoS • Commence planned transfer from ED to MOPRS and Medicine Wards to decrease LoS • Create third General Medicine • Recommence OPAS Frail Elderly model at Front door • Review and enhance MDT Discharge Processes to increase daily discharge Update • 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours)	• SMT • Trust Board • Reviewed at Trust Recovery Group and monthly by TDA • Plan monitored weekly by PHT Urgent Care Task Force chaired by CEO and TDA • Operational Delivery Group • Transformation programme commenced	May 2015	Jun 2015	M Quinn **SMT**

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17-1415 4	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 • Dilution of specialty clinical staff (outliers • Increased likelihood of delay in patient journey • Difficulty in identifying suitable patients can result in complex patients being moved thereby increasing the risk • Financial risk associated with outlaying to G5 (PPU)	• Daily list of patients that are outlied produced and medical team review daily • Clinical staff undertake individual decision making process for each patient moved • Additional SpR and SHO resource winter months 13/14 to provide dedicated review of outlay patients and progress pathways to discharge. • Outlay to G5 criteria QA@H and referral criteria extended to cover social care, bridging gaps • D2 - acute General Medicine admissions ward • G1 commissioned mid September 2014 • Improved access of community beds and spot purchase capacity • Additional Consultant Ward rounds in Medicine at weekends 22 Nov 14 allow earlier discharge decisions/actions and reduce risk of outlaying • Medicine outlier discharges tracked daily via the Medicine CSC discharge audit tracker • Outlier reduction trajectory in place monitored against an opening baseline of 112 outliers as at 18th February 2015. Plan to reduce to 30 and sustain at this level. Performance measured and recorded daily.	16 4x4	20 5x4	12 4x3	• Hospital work in place to increase efficiencies in patient pathway through CQUIN work and Newton • Early Bird Discharge (IDB) work continuing – targets have been set for all CSCs, performance against targets are reported daily via KitBag • Early Bird discharges have been ring-fenced to prevent outlaying of this cohort of patients and the consequential impact to flow the following morning. • Stretch target of 48 discharges per weekend applied to Medicine CSC – associated resource to achieve supported by winter pressures investment. • SHC possible move to D8 and vacated capacity used to extend E4 to 28 beds Update • Daily discharge targets agreed across the Trust with focus on discharges before 1300 and before 1400. Key target –30% of all daily discharges achieved by 1300 and 50% by 1400. Monitored daily. • E4 (18 beds) decommissioned on 9th as per plan • Increasing focus on improving pace of flow supported by Community Partners. Ongoing discussions led by COO.	• Through CSC governance monthly reviews • Monitoring IDB performance on weekly basic as part of Trust Recovery Group • IDB Meetings are taking place daily at 1030am, actions are chased hourly • Progress Chaser role has also been introduced to ensure actions are progressed • Medicine and MOPRS outliers numbers continue to be monitored daily and are reported via the weekly Back Door Tracker • Performance is discussed weekly at Operational Delivery Group • Weekly monitoring of daily unscheduled admissions via ED that result in a LOS <24 hours • Daily system-wide conference calls in place to agree remedial actions as capacity pressures increase	May 2015	Review position May 2015	Mike Quinn **SMT**

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20-14154	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 • Action plan for 2014 was been completed and new processes have been implemented • Mediation agreement reached June 2014 • Monthly department meetings • 6 month review of mediation agreement completed Update • Clinical Fellow appointed to commence Apr 15 • Two locums extended for further year.	**12 4x3**	**16 4x4**	**8 4x2**	• Continuing actions to manage waiting times for cancer and RTT patients • Specialty working on plan for RTT wait times, including different pathway for new referrals (straight to test) Update • Draft options appraisal for the service with Deputy COO for review • Specialty away day planned linked to transformation schemes by July 2015 to cover • Patient pathway • Patient experience • Staff experience	• Review by CSC board • Review by Executive team	Jun 2015	Dec 2016	N Martin **Trust Board**

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21-14154	L, C, F, R, Q&PAssessement	May2014	MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) post Supreme Court Ruling setting out an 'Acid Test' for DoL: • Failure to demonstrate through robust documentation the legal basis for admitting someone to hospital when they lack mental capacity to consent to this. • Failing to apply / delays in applying for a DoLS Authorisation when required resulting in potential unlawful deprivation of a patients liberty. • DoLS Offices struggling to meet demand for DoLS Assessments resulting in 'lapsed' DoLS. • Limited MCA and DoLS trainer within the Trust. • Failure to comply with Coroner notification (all patients who die under DoLS Authorisation)	• Breach of CQC Regulations: Safeguarding people who use services from abuse • Breach of NHS Contract • Potential legal action for unlawfully depriving someone of their liberty • Reputational damage • Failure to meet contractual training compliance • Applying for DoLS Authorisation is time-consuming putting increased pressure on clinical teams. • Current Adult Safeguarding resources will be unable to meet increased workload / data recording and CQC notification requirements • Lack of assurance for internal audit	• Working with local external partners (DoLS Offices and acute health providers) to facilitate the implementation of the Supreme Court ruling (March 2014) • Multiagency training on MCA and DoLS for Trust and CSC Operational Adult Safeguarding Leads, designated CSC staff. • In-house provision of training by Trust Adult Safeguarding Lead. • Briefings on DoLS changes to Corporate Nursing team, Heads of Nursing, Matrons, Chiefs of Service and Clinical Directors. • Monthly Board Exception report. • In-house training material developed and available for all Safeguarding Leads to access • How to apply for DoLS information on intranet (Policy requires updating post Supreme Court ruling) • Interim guidance in place • MCA admission form introduced • MCA and DoLs training strategy agreed • Introduction of shortened application form to simplify process and reduce clinical workload	**16** **4 x 4**	**16** **4 x 4**	**8** **4x2**	• All CSC Safeguarding Leads to undertake local and Trust-wide MCA and DoLS training. - complete • Continued roll-out of attendance on external multiagency MCA and DoLS training. – on-going • DoLS policy update following receipt of guidance received from Department of Health in January 2015. – on-going • On-going work with Legal Department, external DoLS partners and Coroner to ensure appropriate notifications are made in a timely manner. • Repeat MOPRS DoLS audit in other CSCs to establish baseline situation • Extending current minimal admin support to Adult Safeguarding Lead to allow focus on strategic issues • Implement agreed funded additional training • Obtain training compliance % rather than staff numbers (working with L&D)	• Monthly Board exception reports – number of applications, declaration of any unlawful DoL • CSC monthly Safeguarding reports • Monitoring by CSC Governance, Trust Safeguarding Committee and monthly Adult Safeguarding Leads meeting • Analysis of trends and data within Quarterly Safeguarding reports	Jun 2015	Sep 2015	F McNeight/A Taylor **Safeguarding Committee**

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26-1415 26	F / R – Assessment	Oct 2011	THE TRUST IS UNABLE TO ACHIEVE ITS PLANNED YEAR END FINANCIAL POSITION 2014/15	• 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	• **Monthly performance meetings:** with each corporate functions to review financial position in detail • **Pay:** Controls include, budget monitoring and control, workforce strategy committee, temp staffing review meetings and Executive sign off for temporary posts. • **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, Weekly Operational Development Group. • Controls include budget monitoring and monthly performance reviews with Exec team • New performance review meetings now in place utilizing bottom up forecasts signed off by CSC management • KitBag reporting of key metrics fully implemented	12 4x3	16 4x4	12 4x3	Update • The month 12 draft position shows a £657k deficit. This is subject to Audit and the result of the review of the Technical Adjustments (previously advised to the Audit Committee and Board) being conducted by External Audit.	Update • Results of External Audit review of Technical Adjustments paper (expected w/e 24th April) • Results of External Audit (to commence 27th April	May 2015	Review for 15/16 May 2015	Lee Williams **FC**

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29-1415	H&S/R Risk Assessment	October 2014	• PATIENT ADMITTED TO TRUST WITH POSSIBLE VIRAL HAEMORRHAGIC FEVER (VHF)	• Failure to recognize infected patient early • Failure to effectively isolate patient early • Failure to protect staff from risk of infection • Staff refusal to attend to patient • Failure to provide adequate care to patient • Loss of confidence in Trust • Potential legal action against Trust • Failure to identify the most appropriate isolation facilities to nurse patient • Lack of effective control measures	• Screening questions at ED • Escalation process for at risk patient management • Laboratory preparedness • G5 designated receiving ward for possible VHF patient • Formal, minuted Trust VHF committee • Local VHF action plan in place, and has been activated effectively • Personal Protective Equipment training provided by Infection Control • Dissemination of information as per VHF committee decision.	**15 5x3**	**15 5x3**	**5 5x1**	• Major risk mitigation will occur with an end of current West African Ebola outbreak (2014) • Update • Ongoing monthly VHF planning committee meetings until end of West African outbreak	• Monthly Trust VHF planning committee • Annual meeting outside of outbreak setting (residual risk of Lassa/Marburg/Crimean-Congo Haemorrhagic Fevers). • Two patients have been tested for Ebola at PHT (both negative) testing the processes involved. Some minor adjustments have been made, but patient and staff safety have been well maintained.	May 2015	TBD End of international outbreak	R Porter **Trust VHF planning committee**

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30-1415 4	C/F/R/Q&P/SD Risk assessment	December 2014	STROKE SERVICE PATHWAY (INCLUDING FOLLOW UP AFTER DISCHARGE) COMMISSIONING AND PROVISION (MEDICAL, THERAPY AND NURSING) IS SUB-OPTIMAL AND NON-SUSTAINABLE IN CURRENT FORMAT	• Potential for patient harm due to: • Delay in assessment and management of stroke patients • Failure to meet RCP thrombolysis guidelines • Delay at weekend of senior review • Failure to meet national targets and quality indicators • Negative impact on SSNAP score – Trust is in lowest tier • Use of TIA clinic slots for acute follow ups when required	• Weekly review of stroke rotas • Stroke outlier list • Stroke nurse coordinators to assist with thrombolysis • Junior medical staff can assist in TIA clinic • Saturday night thrombolysis locum provision • Nursing recruitment and training • Clinics cancelled where necessary to prioritise thrombolysis • New stroke lead action group now in place and action plan developed and progressing • Stroke Governance forum in place and meeting monthly • Reporting Structure reviewed and streamlined • New SPR rota commenced 06/02/15	**20 5x4**	**20 5x4**	**10 5x2**	• Discussions with commissioners regarding follow up clinic arrangements being progressed with Chief of Service • Implement all key areas for improvement identified from the Royal College of Physicians external stroke review. • Clinical Director post appointed to. • Support of external business consultant in place. • Capacity in CSRT increased to support Flow. • Review of referrals process and pilot of amended to support decision making by more junior staff • Business case to support staff stroke action plan in progress. • Nursing Thrombolysis cover reviewed and interim plan in place pending recruitment • Discussions taking place with other CSC on Joint interim pathways such as imaging • Update • SOP for stroke pathway in progress- plan to launch in 2-3 weeks • Plan to swap F2 and F4 on June 3rd which will deliver 4 more stroke beds and improve the Length of stay target.	• 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 Update • SSNAP improved score in 4/10 domains although still an overall score of a D/E • Minimal stroke outliers over the last 6 weeks	Jun 2015	Jul 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 • Monthly review of Datix and incident reporting for medications by Head of Quality & Medication Safety Pharmacist • Appointment of pharmacist to cover QA@Home patients	• Monthly Clinical Governance Review Group • Monthly Contract Review Group	May 2015	July 2015	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 Update • Solent and the CCGs are coming to an agreement that DSC therapist need to be TUPED over to PHT. Progress is therefore being made at contractual level. Operationally the service remains very fragile, for which PHT are taking all the risk as Solent have been slow to advertise for even a band 3 since February, however t this post is now out to advert. • 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.	• 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	Jun 2015	Jul 2015	Hayley Wagner **CSC Governance Committee**

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34-1516	C L R SD	March 2015	LACK OF CAPACITY TO SUPPLY MEDICINES UNDER SECTION 10 OR FOR CLINICAL TRIALS FROM MANUFACTURING UNIT One pharmacist off sick long term, leaving a single pharmacist who is authorized to release these medicines, there is no cover for annual leave or sickness. Locum pharmacist cover not an option as unfamiliarity with unit and requirements, has potential to increase risk to patients	• Inability to supply medicines to patients as required. • Vulnerability of PMU to provide a service to PHT patients. • Medicines for clinical trials will need to be released by a PHT pharmacist who is untrained in the unit specifics, with the support of a releasing officer for explanation of processes and requirements.	• Remaining authorized pharmacist,	16 4x4	16 4x4	8 4x2	• Band 7 pharmacist newly funded post, started March 2015 which will mitigate risk eventually once trained (likely July 2015) • Investigate feasibility of allowing trained releasing officers (non-pharmacists) who currently release products manufactured under the MS licence, to also release products manufactured for individual patients under section 10 exemption or for clinical trials, and implement. • Whenever possible Schedule manufacture of such products to periods when authorized pharmacist is available. • Pharmacist previously employed by manufacturing unit is undergoing training to update skills in order to undertake authorized release (likely June 2015)	• Releasing officers are assured under the terms of the manufacturing license • Monitoring of incident reporting relating to release of section 10/clinical trial drugs • CSC Governance	Jul 2015	Oct 2015	A Cooper **Clinical Support 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 ○ Likelihood: the likelihood of the risk happening - this score should take into account the existing controls ○ 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 ○ Understand the risk and monitor it through its lifetime ○ Ensure the appropriate controls are enacted ○ 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.